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COMMUNITY HEALTH WORKERS & PROFESSIONAL NURSES: A DESCRIPTIVE STUDY OF THEIR RELATIONSHIP IN TWO WESTERN CAPE COMMUNITIES

by

Tanya Doherty

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DECLARATION

I, **Tanya Margaret Doherty**, do hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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ABSTRACT

Community health workers (CHWs) have become the distinguishing feature of many primary health care initiatives world wide. However, the nature of their role in South Africa's primary health care system has yet to be formally recognised through policy and legislative measures. In addition to the lack of clarity on the role of CHWs at a National level, an even greater amount of confusion exists at the level of service delivery, amongst health professionals. With recognition of the importance of meeting the needs of underserved communities and the shift to primary level care, any health initiative occurring in a community should involve the entire health care team in planning and implementation. It is also imperative to acknowledge that a district health service is delivered predominantly by nurses and CHWs. Based on this acknowledgement, it is evident that without a cohesive relationship between these two groups, we cannot realistically expect the district health system to function.

The aim of this research was to explore the relationship between the community health workers (CHWs) and professional nurses in two informal settlement communities in the Western Cape, South Africa. This study utilised an exploratory descriptive qualitative research design. Participants included nurses and CHWs working in both of the areas. Data collection included individual interviews, focus group interviews, and site visits involving participant observation and field notes. Data was analysed using a thematic content method.

The findings indicate that there is a distinct process involved in the establishment of a relationship between these two groups. This process appeared to follow three phases. These were: an initiation phase, beginning to understand each other, followed by an uneasy co-operation. Certain elements were also noted which influence this relationship in both a constructive and destructive manner. The setting of an informal settlement also impacted on the work environment and experience for both nurses and CHWs and this is described in the study. The outcome of the study contributes to a deeper understanding of the complex relationship between nurses and CHWs in primary health care settings. These findings highlight understandings which will be of use to nurse managers, district health service planners and CHW project co-ordinators in designing a district health service which acknowledges and draws on the skills of all levels of health workers.

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GLOSSARY OF TERMS

Black:

The question of what constitutes a 'black' person in South Africa is ambiguous and begs elucidation. 'Blackness' has been defined in terms of skin colour (as opposed to 'white' or 'coloured'), in terms of categories of oppression (in which case black becomes synonymous with underprivileged), and in terms of opposition to 'whiteness'-black as 'non-white' (Ross 1995). For the purposes of this study, black will be understood in terms of the now defunct Population Registration Act's definition of a black person, and thus considered synonymous with the popular category African. The term black will be used throughout this study

Coloured:

In this thesis the term 'coloured' refers to "those South Africans loosely bound together for historical reasons rather than by common ethnic identity" (Erasmus & Pieterse 1997). The descent and heritage of coloured people are varied and include indigenous San, slaves brought to the Cape Colony from Indonesia and Malaysia, and the offspring of intermarriage between people of mixed European and African descent.

White:

Afrikaans and English speaking South Africans who are of traditionally European descent.

Nompilo:

The Xhosa word meaning *to have health*, which is used as the name for community health workers. In this study some of the nurses and CHWs have used this term when referring to CHWs.

Homelands:

Also known as *bantustan's,* was territory which was set aside under the Apartheid policy for black South Africans. These black states were a major administrative device for the complete exclusion of blacks from the South African political system and were intended for eventual independence. Ten homelands, covering 14% of the country's land, were created from the former native reserves and were organised on the basis of ethnic and linguistic groupings.

These states were rural, under-industrialised, and overly reliant on both subsistence farming and on their citizens' temporary labour in South Africa's cities, towns, mines and farms (Chalmers 1990).

Four of these homelands were proclaimed independent- Transkei (1976), Bophuthatswana (1977), Venda (1979), and Ciskei (1981)- but no foreign government recognised them. Citizens of independent homelands lost the limited rights they had as South Africans. Under the South African constitution that was approved in 1994 and ended white rule, South Africa citizenship was restored to homeland residents and the homelands were abolished. Since this time there has been a marked influx of people from the former homelands to the larger cities in search of work, better resources and opportunities. This has resulted in the increasing growth of peri-urban informal settlements or townships.

Informal settlements:

These informal or 'squatter' settlements have occurred largely as a result of rapid urbanisation and consequently high unemployment. They are situated on the outskirts of most major cities and are characterised by overcrowding in informal housing structures. Houses are mainly built from scrap metal, plastic, cardboard and anything else which can be used to provide a warm shelter. As most of these materials are not bio-degradable, they lie around becoming part of the living environment.

PREFACE

Community health workers (CHWs) have become the distinguishing feature of many primary health care initiatives. International experience in Indonesia, Thailand, India, and China (Berman, Gwatkin & Burger 1987) has shown that CHWs can make a valuable contribution to improving health status in developing countries. The major role of CHWs is to provide basic preventative and curative health care to individuals in their own homes and to form a bridge between communities and formal health services. Interventions performed by CHWs are expected to improve the cost-effectiveness of health care systems by reaching large numbers of previously underserved people with effective basic services at low cost.

The poor coverage of clinic-based services in the above mentioned countries was an important motivation for the CHW approach (Berman et al 1987). The main problem was a scarcity of clinics which were already understaffed. This resulted in difficult access to clinics and increasing lack of faith on the part of community members in the formal health services. According to Berman et al (1987), CHWs are seen as a way to reduce barriers to accessibility and acceptability by increasing service utilisation. Their being residents in the communities they serve, eliminates the discouraging effects of distance, travel, time, expense, and inconvenient clinic hours on help-seeking behaviour. They are usually well known by community members and therefore uniquely suited to translate modern health concepts into understandable and culturally acceptable terms. The results of the introduction of CHW projects in certain areas of the Western Cape have been improved levels of service coverage compared to purely clinic-based care, including reaching people previously neglected by the formal health system (Makan & Bachman 1997).

In South Africa, several CHW programmes have been started during the last decade, initially by non-governmental organisations (NGOs) in marginalised communities. More recently, this has been further facilitated by the national move towards a district-based health system, through devolution of responsibility and activity to the district level. Health planners in both government and NGOs have come to see CHW programmes as a means of improving access to health services in rural and peri-urban areas, and as a mechanism for promoting community participation in health care (van der Walt & Mathews 1994). However, the nature of their role in South Africa's Primary Health Care system has yet to be formally recognised through policy and legislative measures. In order for

CHWs to reach their full potential, there must be clarity on the status and role of these front-line health workers (Cruse 1997).

In addition to this lack of clarity on the role of CHWs at a national level, an even greater amount of confusion exists at the level of service delivery, amongst health professionals. It is evident that the involvement of the nursing profession in planning CHW schemes has been minimal, although it is nurses who staff PHC clinics and have the most contact with CHWs (Walt 1988).

The national restructuring of health service delivery toward a more community-based model is impacting on the role of community nurses. They are having to take on greater responsibilities and deal with large numbers of patients without a corresponding increase in support or staff. Most nurses have received hospital-centred and urban based education which does not prepare them adequately for work in primary health care services (Strasser 1999).

Work in under-resourced or informal settlement communities frequently involves encountering community-based organisations and community health workers. Therefore, community nurses' perspectives regarding their own work, and their interactions with CHWs, significantly influence how they can best fulfil their role within the district health team. The current changes in health service delivery, and the increasing emphasis on primary health care teams, could lead to role conflict and role ambiguity resulting in stress and strain. This could ultimately influence the provision of care. An understanding of the patterns of interaction between community nurses and CHWs can be used to support nurses through the current health system reorganization, while ensuring that their contributions are optimized.

The addition of a new cadre of health personnel would require an adjustment in the traditional role of nurses. Regular discussion, and the continuing education of nurses and other health professionals, would also be required in order for them to fully understand the potential, role and function of CHWs and their relationship to the rest of the health services (van der Walt & Matthews 1994).

It is widely recognised that for CHW programmes to be effective, they need to form links with formal health services and to work together to ensure effective referral and patient management. The importance of linkages to the formal health services in the success of CHW programmes is underlined in a World Bank report published in 1995 which states that, "*If CHWs have no clear*

connection to the existing health system, they are often bypassed by household members who consult providers at the first level of the formal system...". Misunderstanding of the role of CHWs often causes conflict with other health workers and the failure of a referral system that should exist between health workers.

With recognition of the importance of meeting the needs of underserved communties and the shift to primary level care, any health initiative occurring in a community should involve the entire health care team in planning and implementation. The isolation of CHW programmes which has occurred in South Africa, has resulted in many obstacles to collaboration with formal health services and personnel. This has had a negative impact on the ability of CHWs to provide the critical link between the formal health services and their community members. Clarification of the patterns of interaction between CHWs and nursing staff within the district health system was therefore the main focus of this research.

Chapter 1
AIMS AND BACKGROUND TO THE STUDY

1.1 AIMS AND OBJECTIVES

The aim of this study was to explore the relationship between the CHW's and professional nurses in Brown's Farm, Philippi and Masiphumelele, Noordhoek, two peri-urban informal settlements in the Western Cape.

The main objectives of the study were:

- To clarify the present patterns of interaction between nurses and CHWs, in order to provide an accurate description of how nurses interact with CHWs.
- To determine how CHWs perceive their relationship with nurses: how they understand the relationship, their feelings about it, and explanations of it.
- To determine how nurses perceive their relationship with CHWs, how they understand the relationship, their feelings about it, and explanations of it.
- To determine which processes, experiences and organisational arrangements contribute to the existing patterns of interaction between CHWs and nurses.
- To make recommendations to district health policy makers concerning the interaction between formal and lay health workers, and particularly the role of CHWs as members of the district health team.

1.2 DEFINITIONS AND DELIMITATIONS OF THE RESEARCH

Primary Health Care (PHC)

For this study, PHC is defined according to the WHO definition (1978a) as an approach to the provision of health care that is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

In South Africa, PHC is used interchangeably to indicate an approach, specific types of services and categories of personnel. These are frequently referred to as the PHC approach, PHC clinics or services, and PHC nurses. In this study, in order to distinguish between these three usages of the term, the following terms will be applied throughout the study.

The terms PHC will only be used when referring specifically to the approach as defined by the WHO. When referring to health care services, these will be called primary level services which are provided at clinics. Presently, these services are extremely fragmented as curative and preventive care are provided in separate facilities. This situation, inherited from our past, led to duplication and inefficiency throughout the health care system. At present, preventive and promotive health services are provided only by Local Authority clinics. These provide services for tuberculosis, sexually transmitted diseases, health education, nutrition education, family planning services, and well baby clinics doing immunisations and growth monitoring. This service is predominantly nurse driven with a doctor visiting once or twice a week. These clinics, frequently called 'PHC clinics' operate on a sessional basis, so that not all services are available every day of the week (Bi-ministerial task team, 2000).

The majority of curative care at the primary level is undertaken at community health centres which are managed by Provincial Health Departments. This is a predominantly doctor driven service with some clinical nurse practitioners (Bi-ministerial task team, 2000).

There is a national process underway at present to integrate health services in this country in order for patients to receive all the comprehensive health services under one roof. The aim of the Health Department is to place all primary level services under a single authority in geographically defined areas.

Health care projects and services

The health care initiatives included in this study consist of two main groups: (a) non-governmental, non-profit and (b) government projects and services in the health sector. A project is defined as being 'government' or 'non-government' on the basis of its governing or managing body. If a project or service is governed by a body that is not a state structure, it is defined here as a non-governmental project/service.

The non-government projects included in this study are the two community health worker projects and the governmental services are the two community health centres and one local authority clinic.

Community Nurses:

In South Africa, professional nurse training is undertaken at either a college or university. The length of training is four years and results in either a degree or a diploma. During the four years, nursing students complete specific training as guided by national regulations. On completion, these students are able to register as general, community, and psychiatric nurses, and midwives. The South Africa Nursing Council is the statutory regulatory body, which controls standards of training, and all nurses are required to register with this council.

Some nurses working within the primary level services may chose to specialise further within this field. They can complete a one-year course in primary assessment and diagnosis of either adults or children. These nurses are called clinical nurse practitioners.

Community Health Workers (CHWs)

The term 'community health worker' encompasses a wide variety of workers in various countries who have been in existence for years, ranging from barefoot doctors, feldschers and auxiliary nurses who have had up to several years of training (WHO 1978b), to briefly trained primary health workers, variously named volunteers, health promoters and village health workers. The diversity of names reflects the considerable variety of tasks these health workers perform. However, what is important is that the earliest programmes were indigenous attempts to meet local needs (Walt 1988).

In the 1980s there were various attempts to include all CHWs in one global concept. A WHO review of international experience in the use of CHWs suggested the CHW is:*"A person from the community who is trained to function in the community in close relationship with the health care system"* (Ofosu-Amaah 1983).

A later definition suggested that CHWs: *"Are generally local inhabitants given a limited amount of training to provide specific basic health and nutrition services to the members of their surrounding communities. They are expected to remain in their home village or neighbourhood and usually only work part-time as health workers. They may be volunteers or receive a salary. They are generally not, however, civil servants or professional employees of the Ministry of Health"* (Berman, Gwatkin and Burger 1987).

In South Africa there is a standardised training programme, through which all CHWs receive twelve weeks of training from the National Progressive Primary Health Care Network. All CHW projects are funded and managed by non-governmental organisations.

1.3 BACKGROUND TO THE STUDY

I have been involved with the community of Masiphumelele for the past four years. This involvement began when a fellow nursing student and I started a Students Health and Welfare Centres Organisation (SHAWCO) clinic in order to attempt to meet primary diagnosis and referral needs. In this under-resourced informal settlement our involvement grew as we established relationships with the community and started to understand the complexities of health care provision in this setting. We were invited to various community and health provider meetings as SHAWCO co-ordinators and became more and more convinced that CHWs would contribute to meeting some of the community's health needs. A steering committee, which included members of the community health committee, the SHAWCO co-ordinators, a representative from St Luke's Hospice, and local health authorities was formed to discuss the proposition of establishing a CHW project in Masiphumelele. A CHW project was formally proposed by the steering committee and a funding proposal for the implementation of a project was submitted to international funders. Funding for the running costs of the project for three years was approved in July 1998.

After receiving confirmation of funding we began the process of selecting individuals for the four funded CHW posts. The process of selecting the four CHWs was the focus of our undergraduate research study (Juby & Doherty 1998). This study aimed to explore the process of selecting

CHWs within the informal settlement of Masiphumelele, Noordhoek, Southern Cape Peninsula. It's main objective was to describe the recruitment process as it occurred in this community, focussing on interesting aspects of the recruitment procedure and how decisions were made. This study was carried out within an action research framework which allowed for research-based community participation. Methods of data collection included field notes, participant observation and researcher journals.

As a student nurse I had experience working with both community nurses and CHWs in other infomal settlements. My present involvement is with CHWs as one of the co-ordinators of the Masiphumelele Health project. Having been alongside the CHWs in Masiphumelele during their struggle to gain recognition from various sectors of their community, I recognise the bias that I may have towards their interests. I am, however, also a nurse, and in my position as researcher have remained open to both of these groups.

My interest in the subject of the proposed study emerged during this undergraduate research experience. There had never been CHWs in this area and many discussions were held amongst members of the steering committee to explore their role and value prior to the selection of individuals. I found our interactions with the staff at the local clinic as they were introduced to the concept of lay health workers particularly thought provoking, and I decided to explore this further.

Chapter 2

A Conceptual Overview: PRIMARY HEALTH CARE

This chapter consists of a review of the literature relating to primary health care both internationally and within the South African context. Following from this is a discussion of community health workers as distinguishing features of many primary health care initiatives as well as an examination of the lack of clarity on their role within the South African health system. Lastly, there is an overview of nursing in South Africa referring specifically to nurses working at the primary level.

2.1 THE BEGINNINGS OF A PHC APPROACH

Before the 1970s in many countries around the world most health programmes consisted of vertically organised disease control interventions. New medical technology interventions for disease control were becoming available, and these were effective and economical in reducing disease. Only after the 1970s and 1980s did countries begin to perceive a need to expand their health service infrastructure to accommodate the establishment of more comprehensive integrated programmes, and development for the conceptual and administrative groundwork for these was initiated (Smith & Bryant 1998).

During the late 1960s and the early 1970s, the WHO and many individual developing countries were struggling to face the implications of the failure of malaria eradication programmes. It was realised that the main reason for this failure was the lack of a complete continuing health service infrastructure which could reach every household and remain in place. At the same time there was widespread dissatisfaction among people worldwide with their health services, and according to Newell (1988), the problems were: a failure to meet the expectations of populations; an inability of health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies; a wide gap in health status between countries and groups within countries; rapidly rising costs without a visible meaningful improvement in service; and a feeling of helplessness on the part of the consumer with no control over health services.

In the face of these difficulties the WHO began to look more deeply into the distribution, form and roles of 'basic health services'. They convened an international conference in Alma Ata to formulate a new approach to health service delivery. Experiences from developing socialist countries such as China with their barefoot doctors, as well as experiences with non-governmental projects in capitalist countries were presented and influenced the formulation of the Primary Health Care approach in the Declaration of Alma Ata (Newell 1988).

2.2 THE PRIMARY HEALTH CARE APPROACH

PHC is an approach to health and health care that was formulated at a conference at Alma Ata in 1978 (World Health Organisation and UNICEF 1978a). It advocates "the provision of first contact services and basic health care...within the framework of an integrated health service". This approach is based on five major principles:

- Equitable distribution of resources.
- Active community participation in decision making.
- A focus on preventive and promotive health services.
- The use of appropriate technology.
- A multi-sectoral approach.

After the Alma Ata conference in 1978, most countries adopted a PHC strategy as their universal health care system (Chipfakacha 1994). This is a comprehensive national strategy for health, based on principals of equity and affordability, effectiveness and acceptability, participation and efficiency (Zwarenstein & Barron 1993).

The concept of PHC is based on the belief that health services should be appropriate to the needs and resources of the people in the community that they serve. Community participation is one of the fundamental principles of PHC. PHC takes a holistic approach to health, reflecting the belief that health cannot be attained only through improvements in formal health service delivery. PHC is seen and implemented as part of a wider development strategy, promoting interdisciplinary teamwork for development. A progressive PHC approach not only provides comprehensive quality healthcare, including preventive, promotive, curative, rehabilitative, and palliative services, but also addresses the causes of poor health, encourages community empowerment, and prioritises those who are most disadvantaged, ensuring that healthcare is accessible, equitable and affordable to all.

Commitment to the concept of PHC obliges governments to provide an acceptable and equitable level of health for all people within their borders, which allows for full participation in the life of the community and society. Health services should therefore contribute to the achievement of health for all with the PHC approach.

The South African government adopted the PHC approach eagerly during the 1980s. This was done in a selective and gradual manner. Curative health care continued to operate as before. It consumed most of the health budget and was maintained as a parallel system which had no direct managerial links with the PHC system. The policy was only formalised in the White Paper for the Transformation of the Health System (Department of National Health and Population Development 1997). Over the past five years however, this approach has led to a shift in emphasis and resources from tertiary to secondary and primary level services, as formal health workers have been challenged to bring PHC into the context of community development (Ferrinho, Rob & Wilson 1991).

Van Rensberg, Kruger & Barron (1997) describe the intrinsic link between health and development: *"Not only is improved human welfare and health a goal of national development, but health is also a precondition for development. Improvement of health is part of a nation's social development, and health indicators (life expectancy, infant mortality etc.) are used to judge a population's development status".* In South Africa, there are wide disparities between population groups. Certain groups, particularly rural dwellers, women, children and black people, have a far lower development status than others. These groups have lower literacy rates, lower incomes, higher levels of unemployment, and are more vulnerable to disease and ill health.

Under the apartheid regime in South Africa, human development was neglected in favour of technological and economic development. Development was something that was imposed on communities; communities were not consulted. Since the 1994 elections the emphasis has shifted to community driven development, equity, accessibility and acceptability. However development has been slow, as policies had to be re-written, infrastructure put in place, and governance and management structures established.

South African health services are still severely maldistributed along lines of race, place of residence and wealth. The apartheid policy has led to community opinion being ignored and a lack of consultation with users of health services. Zwarenstein and Barron (1993), describe the

situation in South Africa as combining a *"vastly fragmented health authority structure with an extremely centralised and bureaucratic tradition"*. This health system has emphasised and resourced curative care which in general is not effective in improving the health status of the whole population as it is most often undertaken at the tertiary care level with little emphasis on prevention or continuing care in the home setting.

Health reforms were launched as part of the Reconstruction and Development Program's (RDP) 'War Against Poverty' (Koch 1996). But the RDP failed to deliver all that it had promised, and in 1996 was severely downgraded with the launch of GEAR (Growth, Employment and Redistribution). GEAR, an economic policy is based on a different ideology- one more concerned with economic growth and job creation than social development (Head 1996).

This is not to say that progress has ceased; a great deal of development work in South Africa is being carried out by NGOs. Work by Van Rensburg, Kruger & Barron (1997) has shown that NGOs make important contributions in areas where the government has failed to provide resources and infrastructure. They also ensure diffusion of power by (a) widening participation in government decision making, and (b) operating at a community level, thus eliciting support and enthusiasm for, and participation in, development projects. These researchers conclude that NGOs are effective because they can work autonomously, but at the same time in co-operation with one another, government and business.

The White Paper on Reconstruction and Development, published by the Government of National Unity in 1994, outlined the need to develop a national health system (Government of National Unity 1994). The following is a statement by the then minister of Health, Dr N Zuma from the above-mentioned White Paper: *"The health status of the South African population must be viewed within a historical, social and economic framework. Poverty and poor physical and social conditions, such as lack of adequate access to safe water and sanitation and poor housing, have impacted negatively on health status. Whilst a minority population enjoyed fairly high standards of health and health care, a large proportion of the population was seriously disadvantaged through grossly inequitable access to health services and health related information. In addition, health programmes have been vertical, disease focussed and based on theoretical frameworks that are not always sympathetic of community perspectives".*

The reorganisation of health services as mandated by the constitution and the policies of the Department of Health continue to pose challenges to all health workers, whether they are managers or front line workers. Despite changes being legislated, there has been minimal provision of resources in the form of increasing staff quotas and conditions in the clinics, thus health care personnel remain unsupported and severely strained. The need to focus on the vision whilst attending to the details of implementation is clearly the current priority. Keeping the lines of communication open and acknowledging the needs of all stakeholders in the process will enable us to move towards our goals with more certainty and purpose.

2.3 THE DISTRICT HEALTH SYSTEM

In the 1997 White Paper on the Transformation of the Health System in South Africa, the Ministry of Health committed itself to developing a District Health System (DHS). Consequently, a complete structural and organisational transformation of South Africa's health care system is under way.

The district has been identified by the WHO (1988), as *"the organisational unit for the reorganisation and transformation of health care provision"*. The underlying philosophy of this strategy is that health services should be governed by decentralised authorities, which are close to the communities they serve.

Previously, different aspects of health care services in South Africa have fallen under the control of national, provincial and local government. This led to overlap or even duplication of some services, and a deficiency in others, as well as a complicated referral procedure. There was no overall planning often resulting in services being run in an inefficient manner (Clarke 1999). Internationally there is wide support for the district health system as the most appropriate vehicle for the delivery of primary level services.

The WHO (1988) has outlined the strengths of the district health system as follows:

- The district is a focus for decentralisation of political power.
- The district is the natural meeting point for 'bottom-up' planning and organisation, and 'top-down' planning and support.
- The district contains sufficient public service infrastructure for service delivery whilst the focus is near enough to communities to allow a certain transparency of community-wide problems and constraints.
- Most problems can be addressed at a district level. This is particularly true as increasing emphasis is placed on addressing causes of diseases and disease prevention.
- Health workers require sustained support which can best be provided within the district.
- Many key development sectors are represented at the district, thus facilitating intersectoral co-operation and the management of services across a broad front.
- The co-ordination and integration of services and vertical programmes allows for increased efficiency.

The development of a DHS marks the decentralisation of South Africa's health system. A single district health authority will be responsible for community based services, clinics and district hospitals. This will enable local health problems to be identified, and services to be prioritised accordingly. Decisions about health care for each district will be made by the district health authority and not a higher level of the health department. The new system will require decentralisation of power and devolution of resources. It aims to give local people control over their budget and decision making. This should also reduce South Africa's large and complex health bureaucracy, shifting the focus from health service administration to implementation and improved quality of services (Pillay, Mzimba & Barron 1998).

2.4 COMMUNITY HEALTH WORKERS

Frankel (1992) traces the history of CHW programmes to two key origins. The first is an acceptance of the relative failure of facility-based services to provide adequate and appropriate services for the majority of health problems at a reasonable cost. The second is the recognition that health interventions need to be comprehensive and include preventive, promotive, curative, rehabilitative and palliative measures. It is argued that CHWs can assist in providing these services (Walt 1988).

CHWs are an important component of the health service delivery recommended by the WHO as they act as bridges between the community and the health service (Khun, Zwarenstein, Thomas, Yach, Conradie, Hoogendoorn & Katzenellenbogen 1990). In order to supplement the trend of curative based care, various leading NGOs in South Africa initiated CHW projects, in the 1980s. Numerous CHW programmes were initiated in areas such as the former Transkei and informal settlements around Cape Town (Tollman 1994). Evaluation of these projects has shown that CHWs provide the basis for a *"potentially effective community responsive service that ensures adequate access to health services and thereby adequate coverage"* (Mathews, van der Walt & Barron 1994).

These projects do not form part of the National Health Plan however, as there is no structure or plan for CHW involvement in the provision of health care, and therefore no post structure or resource provision. Every formal health profession has specific legislation which stipulates, amongst other things, requirements for training and scope of practice. There are no legislated regulations regarding the training or work performed by CHWs. This is yet another barrier which has hampered partnership with other health providers, especially nurses.

CHW projects are all exclusively initiated and managed by individual NGOs and are characterised by a constant struggle for funding and recognition within a health care system which ignores both their value and the vital role which they fulfil. A study conducted by Mathews et al (1994), consisting of an evaluation of a CHW project in Khayelitsha, highlights the vast discrepancy which exists between the fragmented clinic-based government health services and the few community-orientated NGO projects. One of the most serious differences between these two services is that the Western Cape Regional Services Council, unlike the NGOs, has not attempted to involve community members in developing their health centres. Mathews et al (1994) have shown that NGO health projects have also been far more responsive to referrals by CHWs than the government health services.

In 1993, Zwarenstein and Barron warned that the decentralisation of health services in an attempt to meet primary level needs would result in greater responsibility for health care resting on the communities themselves. CHWs have spearheaded a fundamental change of emphasis towards the PHC approach, from a clinic focus to a community focus, with special attention to the needs of those previously underserved. International experience has shown that CHWs can be trained to focus on priority public health issues whereas clinic nurses, prepared in traditional education programmes, tend to provide curative services only. Research indicates that CHWs can be trusted to perform a wide range of tasks safely (Berman, Gwatkin & Burger 1987).

Worldwide it has been mainly progressive medical professionals who have promoted the idea of CHWs (Walt 1988). In South Africa particularly, it has been doctors who have instigated and implemented successful health schemes training CHWs (e.g. Hewitson, Friedman and Toms) and who have persuaded policy makers and politicians to support CHW programmes. A broad literature search has revealed a paucity evidence of nurses initiating CHW projects. One study which described a nurse initiated CHW project, involved undergraduate nursing students from the University of Cape Town (Doherty & Juby 1999).

It seems therefore, that the involvement of the nursing profession in planning CHW schemes has been minimal, although it is nurses who staff community clinics and have the most contact with CHWs. Thus it is not surprising that CHW programmes were not welcomed initially by the nursing profession (Marchione 1984). Because nurses were not involved in planning CHW programmes they have been slow to understand the broad role CHWs can perform at the primary level and have tended to use them as useful "*extra pairs of hands*" in the clinics, as nurse aides rather than CHWs (Walt 1988).

The study by van der Walt and Matthews (1994) mentioned above, evaluated one of the CHW projects in Khayelitsha and recommended that there should be good communication and referral channels between a CHW project and formal health services, and noted that formal structures and regular meetings are essential to iron out suspicion and mistrust and to build a good team. Walt (1988) reports that worldwide that there is a potential for 'role strain' in PHC teams that include CHWs and nurses, and that conflicts may arise over skills, competence and status. Nurses need to be involved in the planning of CHW projects in order to understand their wide role in providing primary level care. Van der Walt and Matthews (1994) found that the nurses whom

they interviewed had been socialised into a hierarchical system and were generally more likely to give advice rather than listen and respond to community needs.

One difficulty facing health professionals is that they have not been equipped to deal with the complex and often volatile political situation which currently characterises many community settings in South Africa. In peri-urban settlements, CHWs who live in the community are capable of driving community development initiatives. They are at the 'cutting edge' of primary level care and as such can play a pivotal role in improving coverage and access to formal health services. However mutual co-operation, understanding and respect among all health workers and the community are vital to ensure effective patient management and the prioritisation of community needs.

2.5 CONTEXTUALISING THE SOUTH AFRICAN POLICY DEBATE ON CHWs

The issue of CHWs has been debated extensively in South Africa (Makan & Bachman 1997). With the decentralisation of the health system, one would expect that CHWs would be taking on a greater role within the new health districts. However, there is no national policy referring to them and they have no official place in the National Health System.

At a forum workshop on CHWs in 1990, the former Director General of Health, Dr C. Slabbert, reviewed the experience of CHW programmes in South Africa. Despite reference to various limitations, he called for a more focussed approach to the range of issues confronting CHW programmes. The Department of Health's position at the time referred to the *"firm belief that in our PHC programme we need the CHW. The successful implementation of CHW programmes demands avoiding the pitfalls encountered by other countries...the basic goal of the forum is to lay a solid foundation on which all health authorities can build their CHW and PHC programmes"* (Department of National Health and Population Development 1990).

In 1994, the African National Congress (ANC) initially presented strong support for CHWs in its draft policy documents on health sector transformation. CHWs were seen as *"...an important part of PHC...in expanding and improving health services, provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around issues like the need for clean water, sanitation, waste disposal, safe playgrounds and so on, and they can play an important role in empowering people with knowledge and involvement in health issues. They should be*

integrated into health services and paid, like other health workers according to their level of training and skills by the community or by the government" (ANC Health Plan 1994).

Unfortunately, this position had been significantly watered down by the time of the publication of the final health plan. Only one reference to CHWs appeared: *"Local CHW programmes will be encouraged, provided that they are integrated into local health services, but no national programmes will be launched at this point"* (ANC Health Plan 1994). However, the Reconstruction and Development Programme (RDP), in attempting to contextualise the importance of meeting the basic needs of all the people of South Africa, stressed the need to: *"provide core teams for every community health centre and clinic, which will require incentives to attract staff to under serviced areas and increased training of CHWs"* (Government of National Unity 1994). The RDP (1994) also made specific mention that: *"The system must encourage the training, use and support of community health workers as cost-effective additional or alternative personnel".*

Despite popular opinion and an increased lobby from the NGO sector for CHWs, the official government policy released in 1996 made no definitive statement on CHWs. According to Makan & Bachman (1997) the lack of clear support to CHWs contributed to further uncertainty around the sustainability of CHW programmes in South Africa. The above references to CHWs from policy submissions and government, forms the background for examining the current position of NGOs and the Department of Health regarding the role, function and deployment of CHWs.

In response to the lack of a clear policy position on CHWs, the leading training and support organisation of CHWs, the National Progressive Primary Health Care Network (NPPHCN), argued that the RDP priorities fell directly within the ambit of CHW programme activities. It was indicated that the contribution of CHW programmes toward the RDP warranted serious consideration, but despite this common intent and priorities, no direct government funding was forthcoming to CHW programmes (Makan & Bachman 1997).

In October 1994, the NPPHCN submitted a memorandum to the Minister of Health, in which concern was raised about the final draft of the ANC's Health Plan and government policy with respect to CHWs. It was felt that the lack of policy would destroy the notion of community ownership and community-supported organisations, and in turn damage the trust that had been built up by NGOs within communities. It was also pointed out that the issue had seriously contributed to the funding crisis facing CHW programmes. Many programmes operating in

communities where CHWs were the only source of health care available, were on the brink of closure (NPPHCN 1994).

The government's cautious response to the CHW issue is probably best captured by the former Minister of Health, Dr N. Zuma, at a National Assembly budget vote speech in October 1994, where the following statement was made: *"A human resource question for South Africa that is not resolved is the employment of CHWs in the health care system. The human resource committee...is examining the role of CHWs in service delivery. ...Before the National Health Ministry can take a policy decision on this matter we will have to know the financial implication on the health care system. ... I believe that CHWs have a role to play at local level. They may be employed by local authorities or non-governmental organisations"* (Minister Zuma 1994).

Many practitioners with experience of working at primary care level advocate the greater use of community-based health workers to extend access to basic health care. Although significant numbers of CHWs have been trained by health NGOs and continue to operate, especially in underserved communities, as can be seen above, their future is being debated within the context of a *"paradox of policy"* (Lund 1993).

The Department of Health's most recent statement on CHWs was contained in the1997 White Paper on the Transformation of the Health System in South Africa, which states that *:"Further incorporation of community health workers into the public service should not occur at present"*. However many government and non-government professionals continue to motivate their utilisation and expansion as a cadre of health worker (Makan & Bachman 1997).

Despite the vigorous debate on the role and functions of CHWs in the 1990s, considerable confusion remains in the absence of an official policy of how CHWs are to be deployed within the South African health care system. As a result, CHW programmes continue to be surrounded by uncertainty which increasingly impacts on their operations and future sustainability.

2.6 NURSING AND PRIMARY HEALTH CARE

This section outlines the adoption of the PHC approach in nursing. Discussion centres around the training of nurses, as this pertains to the manner in which they practise and the unique challenges which they face with the transformation of the health system towards a PHC approach.

In 1974 a WHO Expert Committee comprising members from different health disciplines met to clarify the contribution of nursing to the health of communities. The committee described the fundamental characteristic of community nursing as the provision of basic health care to the community and in so doing ensuring continuous, comprehensive, co-ordinated, accessible and relevant services to all. The implications that the committee foresaw for nursing education were that community health would form the foundation of all nursing practice and that training in the future would emphasise health and not disease. As a result of this initiative, a comprehensive community health nursing component was integrated into the four year basic diploma course, and to various baccalaureate programmes in South Africa in the 1980s (Dennill 1999).

Despite community health teaching forming part of the curriculum of basic nursing studies, the training of nurses remains largely hospital-based. Most nurses receive four years of basic professional training in a large curative hospital. A directive from the South African Nursing Council (SANC) in 1988, stipulates that students complete at least 300 hours in community settings during their four years of training (SANC 1988). A study which described the problems that nursing students at Carinus Nursing College in Cape Town perceived during their practical training revealed that the students felt insufficiently prepared to work in a primary level setting. They felt that the curriculum prepared them to work in tertiary academic centres where they are required to follow doctors' orders. This did not equip them adequately with problem solving skills and the ability to think independently. Their training did not allow them to view their patients in the contexts where they live and work, nor did it give them an understanding of the socio-political factors which affect health (Edelstein 1996).

Much more so than hospital nurses, the nurses who work at the primary level are directly confronted with the effects of poverty and social pathology. On a daily basis they work with people who are malnourished, unemployed and inadequately housed. Often their patients have to cope without basic health requirements such as running water and an adequate sewage system. Nurses have to do 'health education', such as educating mothers about healthy food for children,

or to teach them about oral rehydration solution. Yet they know all too well that many patients cannot afford to buy the food they are recommending. In theory, the social and economic development of the population should be taken care of by implementation of the primary health care approach. Yet because of the slow and fragmented initiation of this approach there is much frustration and helplessness amongst health care providers who try to cope within an environment of scarce resources.

Nurses form the largest group of frontline health providers in South Africa and have been described by the former Minister of Health Dr N. Zuma, on various occasions, as the "backbone" of our public health system. According to the ANC Health Plan: *"Although South Africa has large numbers of highly skilled health workers, much of their training has been inappropriate and they are poorly distributed in relation to health and health care needs. The transformation of the health system to one based on the PHC approach will require reorientation of existing personnel...There will also need to be changes to basic training"*. As has been said above, the basic training of many nurses is still hospital-centred and urban-based. Students have dual and often conflicting roles as both workers and students. Also what students learn in class may not match what they see in practice and their educators may be out of touch with the situation in the field.

Nurse educators and service providers are now recognising that nurses are not adequately or appropriately trained to meet the needs of primary services. Edelstein (1996) has outlined some common concerns regarding nursing education:

- Lack of reference to common national programmes such as the Tuberculosis Directly Observed Therapy (DOTS) programme.
- Lack of reference to district health systems in training.
- Insufficient opportunity to develop counselling skills.
- Insufficient opportunity to develop management skills.
- Too little practice time spent in primary level settings.
- Infrequent updating of educators.

In an attempt to meet the education needs of nurses, a number of post-basic courses and in-service training programmes have been developed by local governments. Many of these programmes are highly effective in bridging the knowledge-skills gap left from basic training. Unfortunately, these programmes are often not standardised or widely available (Strasser 1999).

Describing the situation faced daily by most community nurses, Strachan (1999) writes: *"In the early morning the scene outside most clinics in South Africa is of a crowd of people waiting for the clinic gates to open. Yet in the afternoon many of these clinics are often deserted. Nurses complain of the overwhelming flood of patients, but the question is if they structured the patient flow so as to ensure a steady stream of patients throughout the day, would the load still be so overwhelming and would the patients still have to wait so long?".* One participant in Strachan's study, a nursing sister working in the Vaal region is reported as saying: *"nurses encourage patients to come early so that they have the afternoons free to do administrative work and check their medicine supplies".* When patients come in the late afternoon, they are seen, but not without a reprimand from the nurse and an instruction to come early in the day the next time (Strachan 1999).

Patients often queue at the gates an hour before the clinic opens, and according to Strachan (1999) this sometimes has to do with the perception that unless they come early they will not get help. Strachan adds that nurses are taught how to nurse, but they are not taught how to plan a day and how to work together as a team. The entrenched hierarchy of nursing often works against attempts to operate as a team.

The feeling of hopelessness and of being overwhelmed by huge numbers of patients has been expressed many times by nurses in South Africa. However, Strachan (1999) says that her research has found that if a clinic is organised properly, it will not be burdened by an overload of patients, and that the key to proper planning is a team approach.

It is clear that despite government policy calling for health services based on the PHC approach, much work remains to be done. Within the nursing profession, basic training needs to be further oriented towards the PHC approach, to ensure that nurses leave basic training with the essential competencies needed to function within primary level services. Post-basic training needs to be better co-ordinated and based on the priority needs of the country. Without well trained, supported and evenly distributed nurses, the health systems as envisaged by the government will not materialise. Nurses have the ability not only to serve as the backbone of the health system but to serve as the driving force of a well-run and highly effective health service. To do this will require further changes to the way nurses are educated and supported in South Africa.

Chapter 3
RESEARCH METHODOLOGY

This section is divided into two main parts. Firstly, a broad introduction to qualitative research, the purpose of using it in this study and a review of health research and qualitative methods in developing countries, and secondly, a description of the specific research design used in this study.

3.1 QUALITATIVE RESEARCH

3.1.1 The Qualitative Approach

The term 'qualitative' has broad denotations. The word itself highlights the primarily qualitative-as-descriptive nature of work within this paradigm in contrast to the primarily quantitative emphasis of positivist approaches (Ely, Anzul, Friedman, Garner & McCormack Steinmetz 1991:4). The psychologist Giorgi (1994:190) states: *"We are living through a pioneering period of qualitative methodology. It seems more and more practitioners of research are beginning to experience the need for nonquantitative but rigorous ways of conducting research".*

To provide a universal definition of qualitative research is a difficult task. As Lincoln and Guba (1985:8), speaking of defining naturalism, state: "*...it is precisely because the matter is so involved that it is not possible to provide a simple definition...*". Ely et al (1991:4) feel that the term 'qualitative research' is perhaps better understood by the characteristics of its methods than by a definition. Several experts such as Lofland and Lofland (1984), Lincoln and Guba (1985) and Sherman and Webb (1988) present lists of such characteristics. The following are the elements of qualitative research as described by Sherman and Webb (1988:5-8) which are common to most qualitative methods:

1. Events can be understood adequately only if they are seen in context. Therefore a qualitative researcher immerses her/himself in the setting.
2. The contexts of inquiry are not contrived, they are natural. Nothing is predefined or taken for granted.
3. Qualitative researchers want those who are studied to speak for themselves, to provide their perspectives in words and other actions. Therefore, qualitative research is an interactive process in which the persons studied teach the researcher about their lives.

4. Qualitative researchers attend to the experience as a whole, not as separate variables. The aim of qualitative research is to understand experience as unified.

From these characteristics, Sherman and Webb (1988:7) formulated the following summary: *"...qualitative implies a direct concern with experience as it is 'lived' or 'felt' or 'undergone'...qualitative research, then, has the aim of understanding as nearly as possible as its participants feel it or live it".*

Those characteristics of qualitative research which are relevant to this study will now be explored further.

3.1.2 Motivation for the use of qualitative research methods in this study

As has been described above, qualitative research is orientated towards an insider's perspective. This is called the **'emic' perspective** by anthropologists and linguists (Holloway & Wheeler 1996:3). It means that researchers attempt to examine the experiences, feelings and perceptions of the people they study rather than imposing a framework of their own which might distort the ideas of the participants. They uncover the meanings which people give to their experiences and the way in which they interpret them. According to Holloway and Wheeler (1996:4) qualitative research is based on the premise that individuals are best placed to describe situations and feelings in their own words. When exploring a programme, project or service, as in this research, statements in the reporting person's own words can provide an accurate picture of their reality, and their experience of the programme.

In this study the main aim was to understand the nature of the relationship between nurses and CHWs, and various methods were used to enable participants to share their feelings and experiences. The free attitude interview employed as the main data collection tool, is in its nature non-directive and should allow participants the freedom to express themselves within a space of acceptance and empathy. Through interviews and focus groups I was able to understand the process by which the participants made sense of their own experiences and the rules which govern their practices.

Qualitative methods are primarily concerned with the in-depth study of social practices in order to understand their nature, and the meanings they have for the individuals involved. Most qualitative research investigates patterns of interaction or seeks knowledge about a group or a culture. In this research, the phenomenon of study was the interaction between community

health workers and nurses. In order for qualitative researchers to gain a full understanding of the phenomenon of study, it is necessary for them to become familiar with the participants' world. This involves what experts call **'immersion in the setting'**. Holloway and Wheeler (1996:4) describe immersion as attending meetings with or about participants, becoming familiar with other, similar situations, reading documents or observing interaction in the setting even before starting the research.

In order to 'immerse' myself in settings for this study, I spent six months visiting both areas before conducting any interviews or focus groups. During this time I familiarised myself with the settings and people and wrote field notes to provide context and description to the data. This time also enabled me to establish relationships with participants and to develop a level of trust. This period of immersion laid the foundation for further more intensive data collection and engagement with participants.

Qualitative research is often called **naturalistic enquiry** (Lincoln & Guba 1985). This means that events and actions are studied as they occur in everyday life settings. Researchers therefore, must respect the context and culture in which they are involved and not try to change it while examining it. As Miles and Huberman (1994:10) write: *"Qualitative research focuses on naturally occurring, ordinary events in natural settings. The data is grounded through its close proximity to a particular situation and is embedded in its context".*

Immersion in the setting will help the researcher generate **thick description.** Holloway and Wheeler (1996:6) define this as *"Detailed portrayals of the participants' experiences, going beyond a report of surface phenomena to their interpretations, uncovering feelings in a situation and the meanings of their actions".* Thick description develops from the data and the context. A feature of qualitative data is their richness and fullness, with strong potential for revealing complexity. This is particularly important in a study where the researcher aims to understand interpersonal relationships and to describe these. It is important to note however, that the ability to obtain thick description is contingent on the researcher possessing the necessary skills and competency in qualitative inquiry, as not only is the researcher an active participant in the research process, he/she is the primary research tool.

In this study there is much description around the context of an informal settlement. This enables the reader to gain an understanding of the unique challenges facing nurses who work in this setting and CHWs who live and work there. The description includes information about the locations and the people within them, providing visual pictures of setting, situation and events, as well as verbatim narratives of individuals' accounts of their perceptions and ideas in context. The photographs are used purposefully to set a context but do not form part of the data analysis.

The qualitative approach could be used to provide a full view of a site including a description and understanding of the context. Qualitative methods permitted me to study selected issues among small numbers of people and in depth and detail. In this study 'site' refers to the two CHW projects and three health centres in which data collection took place. The surrounding communities of Brown's Farm and Masiphumelele are also described in order to ground the data within the context of informal settlements. These sites were chosen in order to provide an understanding of nurse-CHW relationships within two fairly similar contexts.

A qualitative research methodology allowed for each 'site' to be studied in its own terms. Each site was treated as a unique entity with its own meaning and constellation of relationships emerging from and related to the context in which it exists. Unique characteristics of, or processes and problems in each site could be captured, the internal dynamics of a programme, as well as the developmental processes and programme change were described, and an in-depth understanding obtained. Qualitative data are a source of well-grounded, rich descriptions and explanations of processes occurring in local contexts (Miles & Huberman 1984). Quantitative methods of data collection may fail to capture adequately the diversity across sites (projects or services), and to detect important qualitative differences between them. In this study, after analysing the data from each site, the similarity of sites enabled me to combine all the data to increase the diversity of discourse.

In the field of health care in South Africa, where there are as yet few successful national or regional blueprints for the development of an appropriate progressive primary level system, we need to be open to learning and gaining insights from small initiatives, and from past experiences with primary level care. Qualitative research methods are ideally suited to this type of learning as they provide **inductive insights** into social phenomena.

Nurses and CHWs are the two groups responsible for first level health care provision. It seems that to describe the interaction between CHWs and nurses it is vital to focus the data collection on a small sample and thus be more able to interpret as fully as possible the totality of this process within the primary level setting from the participants' frame of reference. A qualitative research approach allowed me the necessary flexibility to study the experience, and behaviour of nurses and CHWs in their work setting, and their perspectives of their interactions. The approach allowed for in-depth inquiry and enabled the researcher to meet the aims and objectives of this study.

3.1.3 Health research and qualitative methods in developing countries

The WHO (1981) recommends the use of qualitative indicators in addition to the use of a range of quantitative indicators for monitoring the progress towards health for all. The use of qualitative methods in studies examining primary level health care initiatives has gained greater acceptance recently as they are able to provide rich and detailed descriptions of people and situations and a depth of understanding of process usually unattainable through other evaluation methods (Matthews 1992).

Training in social sciences and qualitative research methods, the domain of the social sciences, has been given low priority in developing countries. In some ways this is paradoxical since the need for a greater qualitative understanding of the meaning of disease and illness is crucial to introducing health care interventions. This is probably one of the reasons why many public health programmes initially implemented in developing countries have not been successful (Yach 1992).

According to van der Walt and Matthews (1995) there is a tendency in South Africa in the arena of public health to rely mainly on quantitative research as a sound basis for decision making. Some of the reasons which they give for this phenomenon is the dominance of the biomedical model, and the preference given by medical schools to clinical epidemiology. They have also noted a preference among funding agencies for quantitative descriptive surveys which produce rapid results and can show statistical association and causation.

In the past health research in South Africa has been fragmented, unco-ordinated and devoid of a clear research strategy. As a result health research has not contributed to the development of an effective health system. In keeping with the transformation of the health system, the Department of National Health and Population Development introduced the concept of Essential National

Health Research (ENHR) in the White Paper for the Transformation of the Health System in South Africa (Department of National Health and Population Development 1997). This was proposed as an integrated strategy for organising and managing health related research. While it does not give a specific commitment to developing research capacity in qualitative methods, it does recommend the need for epidemiology, economics and behavioural science research to be strengthened. In 1991 the Medical Research Council (MRC) conducted a national level review of health research in South Africa (MRC 1991). Respondents who gave input in the review stressed the importance of developing behavioural science expertise so that the qualitative component of research could be enhanced.

According to Yach (1992), the focus group model is a particular qualitative method that has been under-used in many public health research efforts. This approach has been used extensively in the marketing field, but less so in the health sector. In settings such as those selected for this study, which are marked by racial and class differences, focus groups can be expected to afford a less hierarchical, more enabling and supportive forum for discussion. By contrast, in individual interviews the power differentials between interviewer and interviewee are starker, and at times more inhibiting.

One country which has used focus groups as an essential element of health education to improve child survival is the West African nation of Togo. A study by Eng, Glik and Parker (1990) involved the training of mid-level health workers to conduct focus group interviews with caretakers of children under five years of age. The aim of the study was to develop the capability of the National Health Education Unit to establish qualitative data bases that complimented survey data on maternal practices related to child health. Through the use of focus groups, health behaviours could be investigated and verified by collecting data that allowed actual and perceived experiences to be conceptually connected to observed practices. This research highlights the way in which research methods and practice methods can be mutually reinforcing and can result in a dialogue between two groups of people- in this case between health workers and the communities they serve. Focus groups used in this way lead toward collective awareness of needs, and actions to resolve them.

Globally there is a growing recognition that research is needed to obtain information for decision makers in the public health sector and that the type of research needed includes both qualitative and quantitative components (Yach 1992).

According to the WHO (1990), future progress in developing countries requires greater attention to be given to public health training in general and to the creation of a new type of person- the public health professional. Their belief is that such a person should be able to use the best mix of methods and disciplines to tackle problems.

3.2 RESEARCH DESIGN

3.2.1 Introduction:

An exploratory descriptive research design was used in this study. In this study my central aim was to understand the nature of the relationship between nurses and community health workers in Brown's Farm and Masiphumelele. The main research questions arose from the **study objectives.** These were:

- To clarify the present patterns of interaction between nurses and CHWs, providing an accurate description of how nurses interact with CHWs.
- To determine how CHWs perceive their relationship with nurses, how they understand the relationship, their feelings about it, and explanations of it.
- To determine how nurses perceive their relationship with CHWs, how they understand the relationship, their feelings about it, and explanations of it.
- To determine which processes, experiences and organisational arrangements contribute to the existing patterns of interaction between CHWs and nurses.
- To make recommendations to district health policy makers concerning the interaction between formal and lay health workers, and particularly the role of CHWs as members of the district health team.

These objectives led to the following **research questions**:

- How do nurses and CHWs interact with one another?
- How do CHWs perceive their relationship with nurses?
- How do nurses perceive their relationship with CHWs?
- What processes, experiences and organisational arrangements contribute to the existing patterns of interaction between nurses and CHWs?

3.2.2 Sites chosen for this study

The two sites chosen for this research were the informal settlement communities of Masiphumelele, Noordhoek and Brown's Farm, Philippi. Both of these communities have CHWs working in them and all of the projects are run by Non Governmental Organization's (NGOs). There are formal health services (clinics and community health centres) in both of these areas which are situated in close proximity to the CHW projects.

Both of these sites are target areas of the Initiative for Sub-District Support (ISDS), a sector of the Health Systems Trust which provided funding for this study. ISDS focuses on facilitating collaboration between parties involved in the integration of health services at the district level. I have worked with the Western Cape site facilitator for ISDS and my findings will form one aspect of their wider research around district health service.

3.2.3 Sampling

The target group for this study is community health workers and nurses working in the informal settlements of Masiphumelele and Brown's Farm. Nurses from two local authority clinics and one community health centre (previously referred to as a day hospital) were included in the study. In Brown's Farm the local authority clinic is known as Mzamomhle and the community health centre is known as Inzame Zabantu. The community health worker project is managed by Health Care Trust. In Masiphumelele there is one local authority clinic known as Nomzamo. The community health worker project known as Philisa is co-ordinated by two postgraduate students from UCT, in conjunction with the Valley Development Project, a local NGO.

In qualitative research the strategic selection of participants and research setting is particularly important because of the limited number of in-depth interviews and observation required for thick description. The guiding principle is often the selection of "critical cases", or cases which would shed light on the phenomenon of the study. This procedure is also known as purposive sampling (Patton 1990).

All of the CHWs and nurses in the two sites were made aware of the study through written information sent to each health unit. Individuals were invited to volunteer to be interviewed. English was chosen as the language medium for the interviews. Although this is not the mother tongue of most of the participants, CHWs are required to have a good knowledge of English. This is a requirement for their training and their work involves keeping records in English. This

enabled me to conduct the interviews without the use of a translator. Since translation necessitates the interposition of a third person between the interviewer and interviewee, the researcher is immediately distanced from the 'personal' quality so desirable in qualitative research.

Sixteen individual interviews were conducted for this study - eight with the CHWs and eight with the registered nurses. Six out of the eight CHWs were women and all of the nurses were women. Interviews were held in the workplace of the participants on an appointment basis and at a time deemed suitable to each participant. Each interview was tape recorded and transcribed. Two focus groups were held after the initial data analysis as tools to validate data and clarify emerging themes.

3.2.4 Gaining Access

When contemplating this study I had many mixed feelings about working with these two groups of people: nurses and CHWs. I completed an undergraduate degree in nursing in 1998. In the third year of this degree I spent a one month community placement with the CHWs in Brown's Farm and was sensitised to the potential which exists for people living in a poorly resourced community to provide an effective primary level service to their neighbours. My experience of hospital-based work during my degree was not always as positive. The hospital environment seemed too structured and inflexible and therefore failed to meet people's real needs. I had only one month's experience, over a four year degree, of working with nurses in primary level services. I therefore felt excitement about working with the CHWs in Brown's Farm again as I had a sense of returning to 'old ground', whereas my overwhelming sense around engaging with the nurses was one of apprehension and trepidation as my only prior experience of them was as a student nurse, with them as my evaluators.

Lofland and Lofland (1984:240) differentiate the process of gaining and maintaining trust with the group under study as phases of getting in and getting along. During my phase of 'getting in', after having gained permission from the UCT- Groote Schuur Ethics Committee, I wrote letters to the community health managers of the South Peninsula Municipality and the Provincial Health Authority which co-ordinate the three clinics which I had proposed to use as sites. I also wrote to the co-ordinators of both CHW projects. The purpose of these letters was to introduce the study to the relevant authority figures in the hope of gaining their support and approval.

My next step was to visit each clinic to introduce myself to the nurses and to inform them of the study. I was completely unsure as to how I should present myself to the nurses, whether as a researcher or as a nurse. I am a nurse but do not hold this as a strong identity. I consider my work to be as a community health project co-ordinator primarily and a researcher secondly. Thus I decided to conduct my initial site visits to the clinics out of uniform, and presented myself as a researcher from the University of Cape Town. I was greeted with scepticism and a general unwillingness to assist me. I was told that I had to contact higher management to get permission to interview the nurses and until they were instructed by their superiors about the study they were unwilling to participate. I tried to explain that I had already received approval from the appropriate management structures and that the purpose of my visit was to explain the study to them.

On reflection, I understand that there were more barriers to accessing these nurses than I had realised. These were related to roles and perceptions. Being a young white nurse with a university degree entering an environment with mid-career black and coloured nurses may also have been an impediment to establishing relationships with these nurses. I may have seemed threatening or they may have been afraid of what I might ask. Some nurses may have been jealous that I had 'escaped' the entrapment of clinical nursing as many of them expressed a desire to continue studying and wanted information on the course in which I was enrolled.

The process of gaining access to the CHW sites was remarkably different to what I have just described. Being one of the co-ordinators of the CHW project in Masiphumelele meant that I already had an established relationship with these people. Having worked for one month as a student nurse with the CHWs in Brown's Farm made reconnecting with them easy, and they were very welcoming and helpful.

The dynamic of changing from a co-ordinator to a researcher with the CHWs in Masiphumelele was quite a challenge as, no matter how I tried to explain it, they always saw my research as part of my management role in the project. I also feared that they would 'give me the right answers' because I am their direct supervisor. I also acknowledged the potential for them to describe situations briefly as they would assume that I already knew the context. In order to try and prevent this, I asked them to imagine that they were talking to someone who knew nothing about the project and that enabled them to explain things which they may otherwise have assumed that I would know.

The process which I have described above took place over approximately one year. I visited each facility for 7 months before conducting any interviews and had to walk the fine line between 'contributing' and 'researching' which would serve both the research process and the social unit being studied. This was an important part of gaining access and establishing relationships, although I realised fairly quickly that gaining access is an ongoing process. The trust and co-operation which I established at one point needed to be maintained and built on throughout the study.

3.2.5 Data Collection Techniques

A variety of methods of data collection were used in this study. These included: free attitude interviews, focus group interviews, site visits, and a researcher journal.

An important consideration in qualitative research is the need for more than one method of data collection in order to portray accurately the situation under analysis. Brink (1989) advocates the use of a variety of methods of data collection to enable concurrent validation, seeing the use of a variety of methods of data collection as the most crucial validation procedure in qualitative research. Such variety provides "triangulation", whereby several different methods are employed to broaden the understanding of information obtained during a study. In this study it was important to enrich interview data with participant observation and to validate the findings with focus groups. According to Cormack (1991), it has become popular for researchers to use the balance of triangulation as proposed by Denzen (1970) to counteract the limitations of single research methodologies. Through triangulation, multiple research methods were employed in this study in both settings in order to gain a 'total' picture of the phenomenon.

This study involved different sites, and because the aim was to generate findings which would illuminate practices across sites, a standard opening question for the interviews was used in each setting. This was: "Can you tell me about your work?". Without this there would be a problem of data overload and lack of focus. Detailed and in-depth qualitative information that was not standard across projects/services was also needed in order to understand in a project's unique terms and context, how the concepts in question have been operationalised and to understand the unique problems they have experienced.

It is important to record methodological decisions which affected the process of data collection. In my original proposal I had planned to conduct focus groups as the principle method of data collection along with site visits and participant observations. After a group supervision session with experts in both health systems research and qualitative methodology, it was recommended that I begin my connection with these individuals through individual interviews as this would assist me to establish relationships and would allow a level of trust to be built between myself and the participants. I saw the value of this and therefore decided to conduct individual interviews first, and the focus groups only after the initial analysis.

It was also suggested that focus groups should be used as a method of validating data captured during the interviews and as a way of clarifying issues which were unclear to me. This was the process which was adopted for this study. This sequencing of the relationship from individuals to groups, enabled me, as the research instrument, to have better contact with the nurses, thus improving the reliability of the data.

The following table provides a summary of the process of data collection and analysis:

Time frame	Research activity	Participants involved
January - July 1999	Gaining access: site visits and participant observation	• Nurses in all three facilities • CHWs in both projects
August - December 1999	Conducting individual interviews	• 8 CHWs interviewed • 8 nurses interviewed
January - March 2000	Analysis of individual interview transcripts and identification of issues requiring further understanding and clarification in focus groups	• Some validation done with key informants
April - May 2000	Conducting focus groups	• One focus group with CHWs (six participants) • One focus group with nurses (four participants)
May - June 2000	Final analysis and emergence of descriptive categories	

i) The Free Attitude Interview

The principle method of data collection in this study was in-depth interviews. I have drawn on the basic technique of "Free Attitude" interviewing - a controlled, non-directive interview as taught by Mulenberg-Buskens (1998). The Free Attitude Interview developed its characteristic form during an industrial psychological research study, the so-called Hawthorne Research, in 1929 in the United States. The researchers discovered that when they gave the interviewees the freedom to speak, the information became more relevant than when they used a structured questionnaire. This open type of interview provided them with the kind of information which could be used to solve problems in the labour situation. The psychologist, Carl Rogers, affirmed the method in 1941 when he stressed the importance of the interview technique as a means of reflecting the respondent's feelings in a different context, that of the therapeutic interview (Meulenberg-Buskens 1998).

The Free Attitude Interview Technique, also described as a non-directive controlled depth interview is fundamentally a verbal technique to obtain information. Being non-directive in nature, it opens a space for the respondent to intervene and for the researcher to respond flexibly and sensitively. Meulenberg-Buskens (1998) emphasises the opportunity which this provides for researcher and respondent to assess and negotiate issues of reliability and validity during the research process.

The Free Attitude Interview can be described as a person to person method to obtain information concerning an opinion, while the interviewer remains non-directive. During the interview the interviewer summarises, reflects, stimulates and asks for clarification. Within the framework of the opening question the interviewee has all the freedom to explore her own ideas and suggest new topics, which may be, according to him/her, of importance to the opinion expressed. The main interviewer qualities necessary to conduct a Free Attitude Interview successfully are the feeling of respect for the respondent and the interest one should have in hearing his/her opinion.

I used this technique for all individual interviews. With the permission of the respondents, the interviews were recorded on audio cassettes and then transcribed.

ii) The Focus Group Method

The focus group method, first introduced by Merton, has been widely used in social science research (Merton 1987). It is a purposive discussion of a specific topic or related topics taking place between six to eight individuals with a similar background and common interests. The group interaction consists of verbal and non-verbal communication and interplay of perceptions and opinions that will stimulate discussion. The focus group interview enables the researcher to develop concepts, generalisations and theories that are grounded in or reflect the intimate knowledge of the people participating in the group. Focus groups also permit access to attitudes and perceptions which are more likely to surface by virtue of the interaction within the group (Morgan 1988).

Focus group interviews have a variety of functions: they are important in the planning phase of a study for idea generation; they are crucial to the design of interventions; and they are important when planning a possible implementation process. They also represent a reasonably rigorous method of enquiry and one that is particularly appropriate for researching certain topics in the South African setting (Macun & Posel 1998).

In this study, two focus group interviews were conducted in order to validate findings from the analysis of the individual interviews. One group consisted of professional nurses and the other of CHWs. The groups were conducted separately and were held in a neutral place which was not the work place of either group. It was expected that this would promote greater sharing and ease of discussion. The researcher facilitated each group. The focus groups were approximately forty-five minutes in duration and were tape recorded and transcribed in the same manner as the individual interviews.

A discussion outline was used in order to gain insights from a dialogue among members of each group. This outline was formulated after the analysis of the individual interviews which revealed certain concepts and issues which needed further exploration and understanding. The questions were open-ended to allow for a range of responses, especially those not expected in the discussion outline. (Examples of the questions asked in the focus groups can be found in the analysis section).

iii) Complementary Data: Site Visits and Participant Observation

I undertook visits to each CHW project and health facility during the seven months prior to conducting interviews. According to Spradley (1980:54) the participant observer comes to a social situation with two purposes: (1) to engage in activities appropriate to the situation and (2) to observe the activities, people, and physical aspects of the situation. Selecting participant observation as a data collection tool meant that I had to consider my own level of participation carefully. For the purposes of this study I chose a comparatively detached role which enabled me to be true to my researcher role, as a nurse interested in hearing from nurses and CHWs about their experiences.

During the site visits my involvement in activities included going on home visits with the CHWs and assisting the nurses in the clinics by performing administrative duties. This enabled me to observe the interactions of both nurses and CHWs with their clients. During times of observation I was looking particularly for recurrent events, impressions of the physical setting, interactions between staff, and my own reactions and feelings towards the situation. These observations enabled me to gain an understanding of social events occurring in the different settings and the explanations of their meanings to participants. I was also able to have a fuller understanding of what was said during interviews about processes possibly unique to a particular service.

Visits are, however, extremely labour intensive, so I limited these to approximately five days in each facility. I recorded my observations as descriptive field notes as soon as possible after the observation periods. In the notes I made a distinction between what I observed, what I heard, and what I thought and felt about it. These were then analysed in relation to the interview transcripts to add richness and context to the descriptions.

iv) Research Diary

Documenting in a reflective field journal or other form of systematic account provides both the researcher and the reader with a means by which to monitor the adequacy of rationale for a variety of decisions, as well as personal biases relevant to the study, and to document strategies employed for maintaining 'neutrality' (Lincoln & Guba 1985). The recording of notes describing this experience contributed to my increasing self-awareness.

The purpose of a research diary in this study was to keep a record of thoughts, recognitions, and feelings that I had during the research process. This enabled me to reflect on insights and decisions regarding research design as well as personal responses, as the research instrument, to the data which facilitated or contributed to data analysis.

3.2.6 Data Analysis

A process of interpretation and re-interpretation of evidence was used in this study. The procedure recommended by Ely et al (1991) was used to guide analysis. This is a process of identifying the main themes, creating descriptive categories, and making conclusions about the issues that arise. Other experts in the field of qualitative data analysis who have influenced my analysis procedure are Glaser and Strauss (1967:7). They believe that the process of *"establishing categories is a very close, intense conversation between a researcher and the data that has implications for ongoing method, descriptive reporting, and theory building"*. I consulted grounded theory texts in order to gain greater understanding of analysis techniques and strategies used in this method. This assisted me in maintaining rigour as the techniques of this method are well described in texts like that of Glaser and Strauss (1967). Even though some techniques and concepts were useful, I chose not to use it as the main method for this study as the grounded theory method leads to theory development and this was not the purpose of this study.

The first task was to organise all forms of spoken and observed data into text. Audio cassettes were transcribed and observations were recorded as field notes. All texts were referenced with dates and contextual information and kept in files. I will now illustrate the process that I have followed by describing the analysis of an interview transcript.

I began this process by reacquainting myself with what I was about to begin to categorize. I read and re-read every interview and field note until I felt that I had caught its essence. Next, I wrote notes in the margins of the interview and field note pages to record my first thoughts and feelings on the interview as a whole. It was 'free thinking' of ideas and anything that came to mind was recorded in the page margins.

Strauss and Corbin (1990) refer to a similar process of preparing to work with data, as developing theoretical sensitivity. They believe that this enables the researcher to be aware of the significance of data. Theoretical sensitivity is built up over time through professional experience and reading

widely. Strauss and Corbin (1990:42) state that: *"Theoretical sensitivity refers to the attitude of having insight, the ability to give meaning to the data, the capacity to understand and capability to separate the pertinent from that which isn't".*

In order to provide some direction to the analysis, I wrote down what some experts call 'thinking units' (Lofland & Lofland 1984). Examples of some of the thinking units which were applied to this study include relationships, encounters, roles, groups, practices, social worlds, life-styles, conditions, and interactions. This was the set of categories which I distilled from the literature and my past experience which I could compare with the data I had collected. I considered these units as broadly framed sorting files which could direct and shape questioning of the data. I added a unit which was called 'open'. This served to remind me that the data may contain surprises, and that the thinking units which I had created were not exhaustive.

Now came the task of breaking the data into parts by creating 'meaning units'. A 'meaning unit' is the smallest meaningful piece of narrative that can be given a label. This occurs as one reads the narrative and divides it in some way that makes sense. I highlighted the keywords and wrote labels in the margin. At this stage I tried to generate as many categories as possible in order to keep an open mind and to avoid reaching a premature conclusion.

These meaning units were then labelled. Initially one word or as few words as possible were used to label what each unit was about. These labels were as descriptive as possible to portray accurately the emerging meaning of the text.

Once I had studied and marked the entire transcript I made a list of all the descriptive labels. Labels which seemed to fit together were combined in an attempt to find one label for each similar group. The labels which did not seem to fit together were also grouped in order to compare and contrast them. It was important to remember that labels were not only important because they occurred many times; a label which emerged once only may also have had significance. Once the entire transcript had been analysed in this way, and I was satisfied that the labels described accurately the meaning units, these labels were sorted into main categories and sub categories.

I wrote analytic memos during this process, as this helped to track thought processes and decisions. The process which has been described applied particularly to making beginning categories and it was best not to move too quickly to drawing conclusions at this point. An example of a portion of analysis can be found in Appendix A.

After following this procedure with each interview transcript it was possible to detect themes that occurred across interviews. A theme can be described as *"a statement of meaning that runs through all or most of the pertinent data, or one in the minority that carries heavy emotional or factual impact"* (Ely et al 1991). Certain themes which emerged from the interview data were confusing or required further explanation. These 'misunderstood' themes were found in both the nurse and CHW analysis. I made a list of questions around concepts which I had difficulty understanding, and took these to the two focus groups in order to clarify the issues.

An example of some of the issues which needed more inquiry from the CHWs and which were asked in the focus group included: the difficulties which CHWs seemed to have in talking about painful experiences; their feelings around nurses being responsible for them; cultural aspects of health-seeking behaviour; and how they feel about nurses not living in the community where they work.

Issues which needed clarification from the nurses included: their feelings around working in an informal settlement; what they see as the role of the CHWs in the clinic; how they feel about the working atmosphere in the clinic; and their feelings around not living in the community where they work.

The focus group data was also transcribed and analysed in the same manner as described above. After the final themes had been decided upon I searched the literature for information relating to these themes in order to gain a broader perspective, and to enable me to enter richer dialogue within the main ideas.

3.2.7 Credibility

Qualitative research work has often been criticised by empirical researchers who believe that there is a lack of control over the validity and reliability of the findings. In a qualitative study the researcher is the interpretative instrument. Therefore certain measures need to be taken in order to establish credibility and trustworthiness of the data, analysis, interpretation and reporting on the process.

Being **trustworthy** as a qualitative researcher means at the least that the processes of the research are carried out fairly, and that the outcomes represent as closely as possible the experiences of the people who are studied. The entire endeavour must be grounded in ethical principles about how data are collected and analysed, how one's own assumptions and conclusions are checked, how participants are involved, and how results are communicated. Ely et al (1991) emphasise, however, that trustworthiness is more than a set of procedures. It is a personal belief system that shapes the procedures in process.

Lincoln and Guba (1985) have designed a list of procedures which should be undertaken by the qualitative researcher in order to establish **credibility**. These include: i) prolonged and persistent observation in the field; ii) triangulation; iii) the experience of peer debriefing; iv) searching for negative cases; v) checking with the participants in the study and vi) determining referential adequacy.

i) I had had prior exposure to both of these research sites before embarking on this research. As a nursing student I spent a month with the community health workers in Brown's Farm as part of a field work study. During this time I visited both of the clinics and was introduced to the nurses. My introduction to Masiphumelele was through my involvement in establishing a SHAWCO clinic in the community. Through providing this service I became acquainted with the nursing staff at Nomzamo clinic. I then became one of the initiators of the community health worker project and began to work more closely with the nurses in the clinic. I therefore had substantial knowledge of both community health worker projects and all three clinics prior to conducting this research. The study itself took place over a period of eighteen months, the first year of which was spent on data collection and site visiting.

ii) Triangulation involves the use of a number of methods of gathering data and several approaches to ongoing data analysis. Checking data obtained by a variety of methods is one way of contributing to trustworthiness. Triangulation characteristically depends on the convergence of data gathered by different methods, in this study observation and interview. Guba and Lincoln (1989:241) suggest that researchers seek to triangulate in order to cross-check specific data items of a factual nature, and to check insights, results, conclusions and presentations with the people they studied and with the peer support group. In this study the use of more than one method provided a rich and complex picture of the phenomenon being studied

iii) Portions of the text were subjected to peer review as a form of co-analysis. Individuals involved in this process included my supervisor and two qualitative researchers from the Medical Research Council. This allowed for the interpretations to be challenged or new interpretations presented. I also spent time with the director/ co-ordinator of each CHW project and clinic involved in the study in order to check the interpretations at each stage of analysis.

Rodgers and Cowles (1993) describe the qualitative research audit trail as an essential component of any rigorous qualitative study. It is comprised of a variety of skilfully organised notes related to the contextual background of data, the rationale for all methodological decisions, the evolution of the findings, and the researcher's particular orientation to the data. In this study a comprehensive audit trail was documented in the research journal in order to clarify my thought processes and feelings in sorting and categorising data, and to conceptualise patterns that emerged during analysis. This is summarised for the reader in Appendix C.

iv) Ely et al (1991) alert us to the danger of throwing out useful information if we focus too tightly on the goal of finding convergent evidence. She states that: *"Inconsistencies and contradictions may help us to refine and revise our framework and findings, but they may be just what they seem: inconsistent and contradictory findings that must stand as they are and be reported as such"* (Ely et al 1991:98).

Data that stands out like a sore thumb is sometimes called a negative case. Negative case analysis is the search for evidence that does not fit into our emergent findings, and that leads to a re-examination of our findings.

Negative case evidence can be extremely helpful in guiding qualitative researchers to *"...make data more credible by reducing the number of exceptional cases..."* (Lincoln and Guba 1985:312). It can help qualitative researchers shift their emerging understandings better to describe what they are studying and to be more certain that they have caught some of its essence.

As has been described in the section on analysis, I paid particular attention to labels which may have only occurred once or which did not seem to fit with the emerging categories. This search for disconfirming evidence helped me to re-examine my findings, to reconceptualise categories, and led to a richer, more complex description. The essential idea behind this procedure is that qualitative researchers go though an active process of confirmation, and are willing to change their minds about findings when the data so dictates.

One of the nurses whom I interviewed does not work for the government health service and never has. She was trained in Zambia while in exile and has worked in the NGO sector ever since. She is presently employed by an NGO which runs a CHW project and she is the clinical nurse practitioner who provides clinical support to the CHWs. Her opinions and philosophies were frequently different to the thoughts and beliefs shared by other nurses working in this study. This was especially apparent in the focus groups where her contribution stood out as being remarkably different to that of other participants. I was initially concerned that this would dampen the discussion. However it created an environment ripe for the sharing of ideas and challenges to these. This nurse enabled the other nurses to rethink their beliefs beyond the confined space of what confronts them within the clinic and to contemplate broader public health issues. Data from this participant often offered a 'negative case' scenario. This data stood out from that of the other nurses, presenting different ideas and opinions. It was important to acknowledge, rather than to exclude or ignore her contributions, which added complexity to the discourse.

v) Another process which contributes to establishing trustworthiness in qualitative research is the support group. The support group is seen by many qualitative researchers as their life line - an indispensable part of their research journey. Peers can play several vital roles in helping each other to be credible. Our class of Masters students had a monthly meeting which was an opportunity to share with each other the stage that we were at, any difficulties we were experiencing, or findings which we wanted to share. This group was also instrumental in helping

its members to face possible bias, and possibly painful insights, with grace and empathy, and in ways which resulted in constructive moves forward.

vi) Another criterion for being credible is to engage in collecting data for such duration and in such ways that these are sufficient to help us understand what we set out to study. What 'sufficient' means is often perplexing. The term 'saturation' is often used to describe the stage in data collection and analysis when data repeats itself. According to Ely et al (1991:159) it is at this stage that the researcher needs to trust that it is time to stop. Finding that moment, and then having the confidence and skill to define it and to use it well, is key to qualitative research. During my study I applied this principle, and through ongoing data analysis was able to identify when data was becoming similar and when I felt that I had exhausted the data this investigation would yield.

3.2.8 Ethical Considerations

In the Health Sciences most familiar ethical prototypes stem from human subjects research carried out under the auspices of medical science. Among the qualitative researchers who have described firsthand the ethical dimensions of their work, a common theme is the absence of appropriate models that might have helped these researchers anticipate or better recognise the particular dilemmas they describe.

A utilitarian framework guides our understanding of three well established ethical concepts: informed consent, avoidance of harm, and confidentiality. Flinders (1992) associates each concept with a different stage in the research process - informed consent with the recruitment of participants; avoidance of harm with the conduct of fieldwork; and confidentiality with the writing of research reports.

The first concept, **informed consent,** is grounded on the basic political and legal rights of self-determination. In practical terms, participants should enter into the research voluntarily, and they should know what is required of them before deciding whether or not to take part in any given study. Once this study proposal had been accepted by the Ethics Committee of UCT, I obtained permission for the study from the appropriate health authorities of the Cape Municipality. In addition, entry to the community clinics and CHW projects was negotiated with staff and co-ordinators. Informed consent for interviews and group discussions was negotiated with individual

participants and they were assured that their contributions would be treated confidentially (See appendix B).

At the outset of my fieldwork I visited each site and spent time with the clinic manager or project co-ordinator. The main aim of this was to work out an agreement with each facility that would be of mutual benefit. These agreements centred on expectations, and practical issues of available time and space. I did not want the nurses or health workers to see me as a distant and detached observer, but rather as someone who was present, attentive and fully engaged as a co-worker in the particular facility. I therefore spent time in each setting other than when I was conducting interviews, just becoming acquainted with the people and surroundings.

Informed consent is also a matter of cultural awareness, as the information pathways of language and culture also commanded an influence over how I proceeded with my research. Regardless of individual actions or intentions, the researcher-participant relationship is largely defined by the respective roles, status differences, cultural norms and the very language in which the communication takes place. This recognition is the first step in developing a sensitivity to the cultural differences that exist between and within social groups.

This was particularly pertinent to my interactions with the CHWs in both sites. Despite having negotiated consent and arranged suitable times for interviews, it frequently occurred that a person I had planned to interview would not arrive at the prearranged time. At first I found this annoying and began to feel anger towards the person who had let me down. However, after discussing this with the person the next time I met them, I discovered that my understanding of the notion of appointments and time was very different to theirs. If they were doing home visits and encountered a family who required lengthy assistance then that would take priority.

Once this had been explained to me I began to understand that it was not simply forgetfulness which had led the person to miss my appointment, but rather prioritisation of work. It was then easier for me to plan further appointments in a more flexible manner. I also had to change my mindset from regarding a missed appointment as a wasted trip but rather as an opportunity to spend time in the site and to strengthen my relationship with the participants. These incidents reminded me that the process of informed consent - giving information, reciprocating or collaborating with others - requires a special sensitivity to aspects of our social and professional lives that are otherwise taken for granted.

The second consideration, **avoidance of harm**, introduces ethical concerns that impinge on research regardless of the researcher's ability to secure informed consent. This concept holds that even when participants are fully informed and freely agree to participate, researchers are morally bound to conduct their research in ways that minimise potential risk or harm to those involved. Flinders (1992) cautions that the avoidance of harm standard demands both too much and too little from those who practise qualitative research. It demands too much in the sense that physical harm is usually not germane to the procedures at hand. But avoidance of harm conceived in this way also demands too little, because it fails to recognise the full range of possible consequences that may result from taking part in the research.

I was conscious that nurses and the health authorities may feel threatened by a study like this, especially at a time when there are so many changes with the introduction of the district health system. I therefore had to be especially aware of my own role as an outsider-researcher and insider-professional nurse with previous contact with some of these services.

A third consideration, **confidentiality**, is intended to protect research participants from a particular type of risk - stress, embarrassment or unwanted publicity resulting from the publication of research findings. Confidentiality also protects participants in situations where the information they reveal to a researcher can be used against them by others. Procedures for maintaining confidentiality typically involve the use of pseudonyms or coding systems. In either case, the researcher's aim is to conceal individual, place or specific group identities. In this thesis the participants are thus not named but indicated by codes relating to the interview transcript. However it has been necessary to describe sites in order to provide adequate understanding of context.

Protecting confidentiality is a more difficult process in qualitative research than it is in other types of research. Flinders (1992) suggests that one reason for this is that most qualitative investigations strive to render vividly the lives of those studied. Detailed portraits and 'thick descriptions' do not lend themselves to disguising an individual's identity. On this count, the better the research, the more readily others can recognise participants, and the more readily participants can recognise themselves. In the consent form I guaranteed participants that they would be kept anonymous in the research report. In order to ensure this I used codes to distinguish between participants without revealing their identity or place of work. Participants gave permission for their photographs to be taken and published in this thesis.

As more has been written about the ethical debates concerning qualitative research, there appears to be a clear shift away from the ethics considered thus far, and toward a deontological framework (Sieber 1982). This deontological framework is distinguished from utilitarian ethics by its assertion that moral conduct cannot be fully validated on the basis of consequences alone. That is, an action may bring about good results, but it is not deontologically correct unless that action also conforms to ethical standards such as honesty and justice.

Chapter 4
DESCRIPTION OF STUDY SITES

This chapter consists of a description of the two study sites, namely Brown's Farm and Masiphumelele. It includes a brief history and description of the health services in these two communities. This enables the reader to have some insight into the establishment of these informal settlements, and the struggles involved in gaining essential facilities and resources. A background is also given to the establishment of both CHW projects. The source of data on the history of Masiphumelele is augmented by a report of the Development Action Group (DAG 1996) and the source of additional data on the history of Brown's Farm is from a report of the Health Care Trust (Lloyd 1999). Both sections contain data from participant observation and field notes.

4.1 MASIPHUMELELE

4.1.1 History of the community

Site Five, or Masiphumelele, is an informal settlement just outside Noordhoek in the Southern Cape Peninsula. It originates from three separate informal settlements, and its establishment involved a long and bitter struggle for land rights in a white group area.

This struggle began in the 1950s when the Apartheid government declared the Southern Peninsula a white group area, and forcibly removed all coloured people living in the areas of Noordhoek, Kommetjie, Fish Hoek, Simonstown and Redhill to the new 'dormitory' town of Ocean View, near Kommetjie. No provision was made for blacks, however. The men's hostels in Simonstown, home to many dockworkers, were closed down, and a settled black community at Redhill lost their land. Men who were employed by the Regional Services Council (RSC) Road Works near Scarborough, the Cape Point Nature Reserve, or on the farms in the area, continued to live in single-sex hostels, but their wives and families were not allowed to live with them. For black people working in Fishoek, Simonstown or Noordhoek the choices were stark: either travel some thirty kilometres daily from the designated black townships of Khayelitsha, Langa and Guguletu, or settle illegally on vacant land.

Many people found the second option easier. Slowly families began to move into the bush around Noordhoek, Fish Hoek, Kommetjie and Hout Bay. Over the years they were hounded by

police, who arrested them for trespassing on private or public land and demolished their shacks. Having little choice, they would return and build again. Many people were employed as casual labourers, domestic workers and gardeners in the surrounding areas. Their incomes could not cover the cost of commuting. In the late seventies, many farmers in the area began selling off their land to be redeveloped for housing. Farm workers lost their jobs and houses but preferred to stay in the area, as there was plenty of work in construction, and employment for both men and women in the new housing developments. They too had no legal place to stay, and joined the rapidly growing informal settlements.

The government scrapped influx control in 1986, but under its new policy of Orderly Urbanisation, squatters in all the peri-urban informal settlements around Cape Town were threatened with forced removal to Khayelitsha, on the outskirts of the city. There was still a barrage of legislation which could be used to move people, including the Prevention of Illegal Squatting Act, the Trespass Act, building regulations, health regulations and Slums Act.

On the 2nd of December 1987, all the families squatting on private and public land in the Noordhoek area were forcibly removed. The Weekly Mail described the events: " *In what has been described as the biggest forced removal in the Western Cape in recent years, 600 squatters were woken by armed police at dawn and ordered to dismantle their shacks. Late that afternoon they were taken to Khayelitsha".* Suddenly, this community of 600 people found themselves herded together in lines of green plastic tents on a windswept expanse of sand, 30 kilometres from their homes, and their livelihood.

As soon as the initial shock had worn off, a committee was appointed to plan their return to Noordhoek. With the help of lawyers they put together a Supreme Court Application challenging the forced removal. In April 1988, Judge Howie of the Supreme Court Division handed down a judgement granting the Noordhoek squatters the right to return to the land. He ruled that the removal was unlawful, in that the responsible authorities had taken the law into their own hands, and had failed to go through due process of the law.

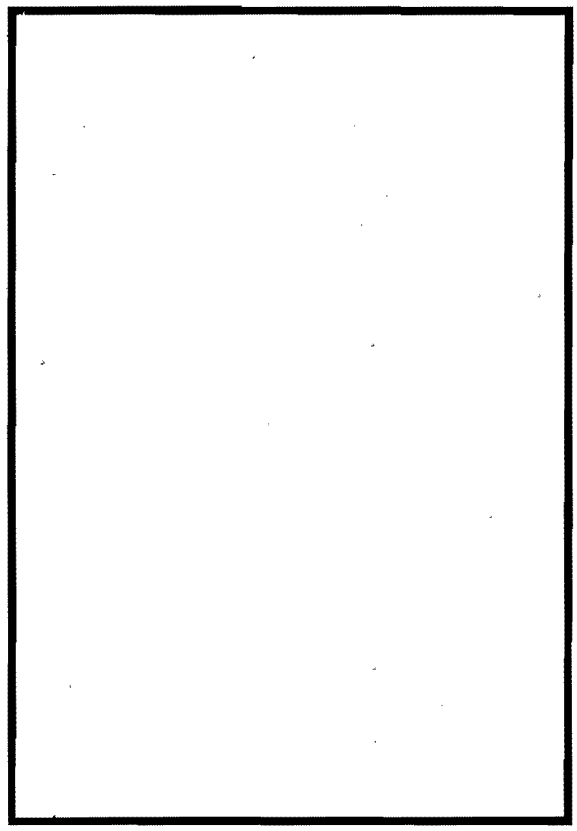
This was a major victory for the squatters, and it served to unite them further. The court case generated widespread publicity, and the media resounded with condemnation of the government's actions. Triumphantly, the squatters set about loading their belongings on to the private vehicles of whoever was prepared to take them, and made the trip back to 'their' bush.

There was an atmosphere of celebration in the community as homes were rebuilt. Their troubles were, however, not yet over. The Court Order, known as a Spoliation Order, merely granted them the right to 'undo what had been done' to them. It did not grant them the right to land in Noordhoek. A long struggle to remain in the area lay ahead. The community wrote to Chris Heunis, then Minister of Constitutional Development and Planning, to request a permanent place to stay.

In December 1992, after two years of negotiations, the long battle of the Noordhoek and Fish Hoek 'squatters' was finally over, and they moved onto their permanent site. They named their new settlement Masiphumelele, meaning *let us succeed.* This was a major victory - not only was this the first time in South Africa that land was allocated for black people in areas that had been exclusively reserved for whites, it was also land that the community had chosen (DAG 1996).

Over the next few months many meetings were held with the Regional Services Council to plan services and the official layout of the area. By the end of 1992 roads had been built and the 500 serviced sites each had an outside toilet, a tap, and weekly refuse removal services. There were no health services in Masiphumelele and people had to travel to False Bay Hospital in Fish Hoek for health care. In 1993 the Independent Development Trust (IDT), a South African funding organisation, offered to fund the building of a clinic.

The Nomzamo Clinic (meaning *efforts*) was built in 1995 and was staffed by two registered nurses, one staff nurse and an assistant nurse. It was managed by the local authority which was the South Peninsula Municipality. This clinic offered basic mother and child services: growth monitoring, immunisations and family planning, as well as the curative services for tuberculosis and sexually transmitted disease treatment.



Masiphumelele Informal Settlement

Illustration 1: **Aerial photograph of the Noordhoek Valley**

4.1.2 Description of the Area

Masiphumelele is a peri-urban settlement in the southern Cape peninsula. It is situated in the Noordhoek Valley, sixty kilometers from the centre of Cape Town. Masiphumelele lies between the traditionally white settlements of Noordhoek and Kommetjie, and is accessible from the Kommetjie Main Road.

When driving into this community one is often greeted by a large male goat which lies under the "Masiphumelele" sign at the entrance to the community. The first thing that strikes one is the music which can be heard echoing out of almost every household or informal vending stall. This community is filled with music. People in the streets are moving to the rhythms and children are dancing. There is a very vibrant and lively atmosphere. Even inside the clinic one can still hear the sounds of music filtering in.

Masiphumelele's eastern boundary, and part of the southern boundary, are marked by a high wall, designed to (a) keep the residents of Masiphumelele from expanding into adjacent areas, and (b) to screen the settlement from neighbouring landowners in Fishoek and Kommetjie. The contrast on either side is striking. Inside the walls the land is barren. Sand and dust fill one's shoes and permeate the rudimentary shacks built from wood and corrugated iron. Over the wall can be seen the roofs of expensive suburban houses, many of which have swimming pools and large irrigated gardens.

The layout of the community appears to work well, as the sites allow for lodger dwellings and other activities such as gardening. Many homes have vegetable and flower gardens and the smaller streets have created a quieter homely atmosphere. By contrast, the main Pokela road is particularly active, with numerous informal vendors and 'spaza' shops.

The Valley Development Project (an affiliate project of Catholic Welfare and Development) provides adult literacy classes and has offices which are situated behind the clinic. They also manage a crèche which is located in wooden bungalows next to the offices. There is a primary school opposite the clinic which has a total of 940 children. Churches of various denominations are situated throughout the community.

Nomzamo clinic is situated on the main access road into Masiphumelele. The staff is comprised of three professional nurses, a staff nurse, an assistant nurse and two clerks. There is a doctor who visits the clinic twice a week on a Wednesday and Friday morning. Services at the clinic are predominantly preventative and promotive, with limited paediatric curative care. The only adult curative care is for Tuberculosis and Sexually Transmitted Diseases.

ii) The community health worker project

The CHW project was initiated in 1998 by a group of concerned individuals from Masiphumelele, the University of Cape Town (UCT), and NGOs in the Noordhoek/Fishoek area. An initial pilot study was conducted by two nursing students at UCT, in order to determine the need for CHWs. Results indicated that there were people who required care at home and that many people were not aware of the clinic and the services which it offered.

The CHW project was proposed in 1997 and a funding proposal was submitted. Funding was secured in June 1998 and four individuals were chosen from the community by means of advertising, short listing and interviewing. A participatory action research study was conducted by the two nursing students who had proposed the project. This study investigated the process of selecting the community health workers (Doherty & Juby 1998).

The community health workers underwent 12 weeks of training in Primary Health Care and Health Education hosted by the National Progressive Primary Health Care Network (NPPHCN) and started to work in the community at the end of October1998 as CHWs. The CHWs have named this project Philisa Community Health Project, as 'Philisa' means 'to heal'.

The project was initially proposed to provide home care but the community felt that their greatest need was first education and health assessments to build relationships before the health workers would be trusted by community members to look after individuals with HIV and chronic illnesses at home.

The main focus of the health workers is to conduct home visits. The community has been roughly divided into 4 areas and each CHW is in charge of an area. The initial home visit is to assess the health status of the family and to discover any potential problems e.g. defaulting on treatment. The health worker will then refer and even accompany the individual to the necessary referral site. The home will then be revisited to ensure that advice was adhered to or whether the

individual has attended the clinic or the day hospital. Each month approximately 200 families are visited for the first time and 100 families are followed-up.

The CHWs have been working closely with the clinic staff focusing on people who have defaulted on their TB treatment. They have attended the Directly Observed Treatment Short course (DOTS) and are supervising the treatment of individuals who work or are too ill to get to the clinic.

The Philisa Health Project is managed in co-operation with the Valley Development Project (VDP). The finances are directed through the VDP although the Philisa Health Project is not formally recognised as a VDP project. The co-ordination and daily running of the project is managed by Tanya Doherty and Chantelle Juby, two registered nurses who have been involved with the project since its initiation. This project is therefore seen as separate but complementary to the functioning of the clinic. The CHWs have a room in the clinic from which they operate.

4.2 BROWN'S FARM

4.2.1 History of the Community

In 1986, fights broke out between members of the Crossroads community and the police. Many residents lost their houses in fires started by the police. Many of these homeless people then moved into church halls nearby or into three main areas each falling under a prominent community leader:

(1) Millers Camp - Mr Sipika
(2) Lusaka Camp - Mr Yamile
(3) Brown's Farm - Mr Toyise

Meetings were held amongst the people in the church halls and everyone decided to pay R10 for a lawyer to fight for land for the whole group. The community leaders played an important role in negotiations, which led to these individuals getting land.

In 1988, the government bought a large farm from Mr Brown who had moved overseas. The land was then developed into 2 310 sites with running water, flush toilets, roads, street lights and public telephones. Each community leader was allocated 770 sites to divide amongst their people. In 1989, the people were transported into the Brown's Farm area to take occupation of their

allocated sites. The residents approached an organisation known as Health Care Trust to run a first aid course for the health committee as there was no form of health care and they thought that this might meet some immediate needs.

Health Care Trust is a non-profit, non-governmental organisation established in 1979 in Cape Town. The mission statement of Health Care Trust is to focus on providing comprehensive primary level services in disadvantaged squatter and rural communities. It seeks to work with other organisations in achieving equitable distribution of health resources and engaging health institutions and services in recognising health as a basic right (Lloyd 1999).

The first project of the Health Care Trust was the Village Health Worker (VHW) project in Cala, Transkei. The Cape Town Community Health Project (CHP) was initiated in 1982 and was primarily producing and distributing resource materials and responding to requests from communities (training, provision of first aid, etc.). In the late 1980s, Health Care Trust started receiving requests for assistance with the initiation and implementation of long-term community based projects. This led to the establishment of various programmes including those that Health Care Trust remains involved with including the two CHW programmes in Brown's Farm, Samora Machel and Wallacedene informal settlements.

4.2.2 Description of the Area

Brown's Farm is a peri-urban informal settlement approximately 21 kilometres from the centre of Cape Town. It forms part of a larger region known as Philippi which is part of the Cape Town central substructure.

Brown's Farm is divided into serviced and unserviced sections. The serviced sections were developed prior to the movement of people into the area and are carefully divided into demarcated sites. Although there are no official records of the population of Brown's Farm, it has been estimated that there are approximately 12 500 sites, of which 3 223 are serviced. The community of at least 48 000 people is continually expanding, and the population of the unserviced area is therefore difficult to determine. The movement of people in and out of the community is occurring rapidly and at a far greater pace in the unserviced region.

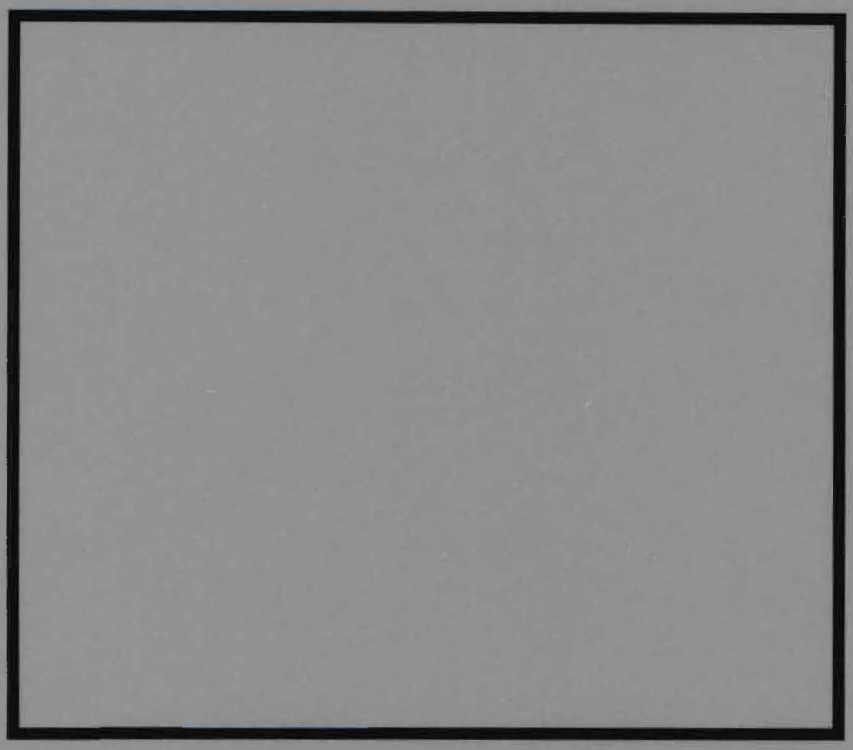
The serviced sites are provided with one flushing toilet situated outside each house, with a tap attached to the outside of the toilet. An electricity connection is provided and electricity can be

bought on a unit system from local shops. Refuse removal is provided on a weekly basis, the streets are tarred, and there are drains and pavements. Public telephones are situated near prominent buildings such as the two clinics, the post boxes, the housing office and the schools.

Illustration 4: **Entrance to Brown's Farm from Lansdowne Road The sign says "Welcome to Philippi"**

In the unserviced areas none of the above services are provided and there is very little infrastructure or control. Taps are situated in open areas and one tap usually serves 200 houses. The women in the community carry water in 25 litre containers and often have to go to the tap five times a day to get sufficient water to meet the needs of their families. The water often stands for long periods of time in the home and this places it at risk for contamination which the health workers believe is a major cause of diarrhoeal disease in the community. No refuse removal services are provided and refuse is either burned or dumped into pits on the edge of the settlement. Pit latrines are used as toilets and have to be dug to a depth of 6ft.

Various committees and authority bodies exist in the community, namely the health committee, street committee and residents' committee. These informal governance structures function to keep control and order in the area, to make decisions, and to represent the residents at broader local government levels.



Brown's Farm Informal Settlement

Illustration 5: **Aerial photograph of Nyanga/ Philippi area**

The street committee's role is to allocate sites to new residents and to hold general meetings when problems arise. An example of a problem recently discussed at a street committee meeting involved an incident in which a man had been drinking excessively and was abusing his wife and causing a disruption to the neighbours. This problem was brought to the attention of all the residents at the meeting, which raised the general awareness about abuse and led to problem solving discussions for future handling of the matter. The health committee consists mainly of CHWs who hold general meetings to discuss issues pertaining to health and to hear the feelings of the residents about the health services being provided.

4.2.3 Health Resources

i) Formal Health Services in the Area

There are two clinics in Brown's Farm: a local authority clinic situated approximately three kilometers from the CHW project, and a 'day hospital' (now referred to as a Community Health Centre) situated next to the CHW Project. The local authority clinic treats children under six, offering curative and preventative health care services. Staff also manage tuberculosis and sexually transmitted diseases. The community health centre treats ill adults and children over six years.

The local authority clinic is known as Mzamomhle clinic (meaning *successful efforts*). It is a brightly coloured, large building which stands out as it is the only brick built structure in the local surroundings. There is a large waiting room and several consulting rooms.

Illustration 6: **Mzamomhle Clinic**

The interior looks modern and well kept with benches for people to sit on while waiting. There are 9 sisters working in this clinic. Two of these sisters run a mobile clinic service to surrounding areas. The main services offered by this clinic involve maternal and child health. Until recently services were mainly preventative but since the middle of 1999 the sisters now see ill children. Training for this new service involved a one month primary diagnosis and treatment course at Red Cross Children's Hospital. Other services offered include immunisation, growth monitoring, treatment for sexually transmitted diseases and tuberculosis, family planning and management of malnourished children.

The 'day hospital' is known as Inzame Zabantu clinic (meaning *efforts of the people*). It is situated in two converted containers on the same site as the CHW project. There are three sisters working in this clinic and one doctor. The clinic is very small and cramped. Patients stand in queues across the parking area as there is no waiting room. On my first visit to this clinic I spent some time with the Sister in charge who informed me about her innovative attempts to gain private funding for a waiting room. Her attempts were successful and an undercover waiting room joining the two containers has been built. Nurses and doctors at this clinic treat ill adults and children, dispense medications and family planning methods and dress wounds.

ii) The Community Health Worker Project

Health Care Trust started working in Brown's Farm in 1989, following a request from The Ecumenical Action Movement (TEAM) and the Brown's Farm Residents' Committee to run health workshops in the area. To develop a need analysis of the area, Health Care Trust, together with the community, did a door to door survey. The survey identified the training and support of a CHW programme in the area as a priority. While consultation with community structures and leaders was taking place, Health Care Trust started running training programmes, health screenings and community health education programmes. This enabled them to obtain more detailed information on the health status and lifestyles of the community.

The organisation also started assisting the community in advocating for better health and related services in the area, such as the weekly mobile clinic run by SHAWCO (Students Health and Welfare Committee), a student-run organisation of the University of Cape Town. In 1992 a joint venture was started by the HCT and the National Progressive Primary Health Care Network (NPPHCN). Through its committed support HCT developed a trusting and supportive relationship with the community structures in Brown's Farm. A representative Health Committee

Four more CHWs were trained, and a more effective referral system was established.
In early 1995 the community of a neighbouring informal settlement, Samora Machel, requested Health Care Trust to assist with the development of a CHW programme. Samora Machel is a recently developed informal settlement with plans for phased expansion. Currently there are 35 CHWs in Browns Farm who serve a population of approximately 48 000 people (Lloyd 1999).

There is a clinical nurse practitioner who is employed at the project as well as a doctor. The doctor works twice a week in the morning, and the sister three days a week. The health workers run a clinic twice a week from this container which is for ill adults and children. It is mainly for the referral of individuals seen on a home visit during the week that could not be managed by the CHWs. The patients are seen by the doctor or sister and given the appropriate treatment or referred to another facility. Basic medication, according to the Essential Drugs List, is kept in the container. There is a permanent co-ordinator that works at the site and controls home visiting, statistics and managerial duties. The project director is situated at the Health Care Trust office in Observatory and visits the site on a weekly basis.

Walking through Brown's Farm one sees many children playing in the streets, creating games and toys from scraps of metal and wood which they find. The only vehicles one sees are taxis as very few people in Brown's Farm own their own cars. There are many animals wandering around this community. Many families keep horses, cows or sheep and these animals forage in the piles of refuse lying between the houses. This creates the atmosphere of a rural area, yet one can see the buildings and smoke from the Philippi industrial area alongside, as a reminder of its peri-urban situation.

Brown's Farm has undergone much growth and development, with many structures becoming permanent, improvements in roads, more organised health services and funding from many non-governmental organisations. This has made Brown's Farm a very dynamic community and is reflected in a sense of hope and an atmosphere which is busy and vibrant.

Chapter 5
REPRESENTATION OF THE STUDY FINDINGS

STRUCTURE OF STUDY FINDINGS

Analysis of data captured during this study yielded three major understandings:

1. The experiences of working in an informal settlement.
2. The process of the relationship between nurses and CHWs.
3. Constructive and destructive influences on their relationship.

This chapter has therefore been divided into the above three sections. Within each of these sections I have constructed a table which presents the major findings. This serves to guide the reader through the chapter and to highlight the different experiences of nurses and CHWs.

In the following chapters, where narrative is presented, this has been indented and is in a smaller text. This enables the reader to distinguish participant voices. The code which is in italics at the end of each quote has been used to protect the identity of participants while enabling the researcher to keep track of data. English is the second language of all participants, so data is reported verbatim unless grammatical structure is lost or can be overly confusing to the reader. In these instances clarification is provided in italics.

5.1 THE EXPERIENCE OF WORKING IN AN INFORMAL SETTLEMENT

> **"When you are in such an area, you tend to be part of the people who are here. But then sometimes your hands are just tied".** *(RN5)*

Working in an informal settlement has its own unique challenges, largely related to the cycle of poverty which characterises this setting. These challenges are perceived differently by the nurses and the CHWs. For the one group this is their work setting and for the other it is their home.

This section provides a description of both nurses and CHWs experiences of working in the informal settlements of Brown's Farm and Masiphumelele. The experiences between the two communities were so similar that they were easily comparable are thus being presented together. This method of reporting was also chosen to protect the identity of the participants as there were

only two communities involved in this study. The descriptions are yielded from the analysis of interview and focus group data.

NURSES	CHWs
Feelings of powerlessness	Broad focus beyond curative work (skills development)
Perceive work as valuable and worthwhile	Networking and collaboration with other resources
Emotional involvement	Leadership role within the community
Sense of belonging	
High mobility of patients results in frustration	
Exposure to traditional healing	

5.1.1 Experiences Of Nurses

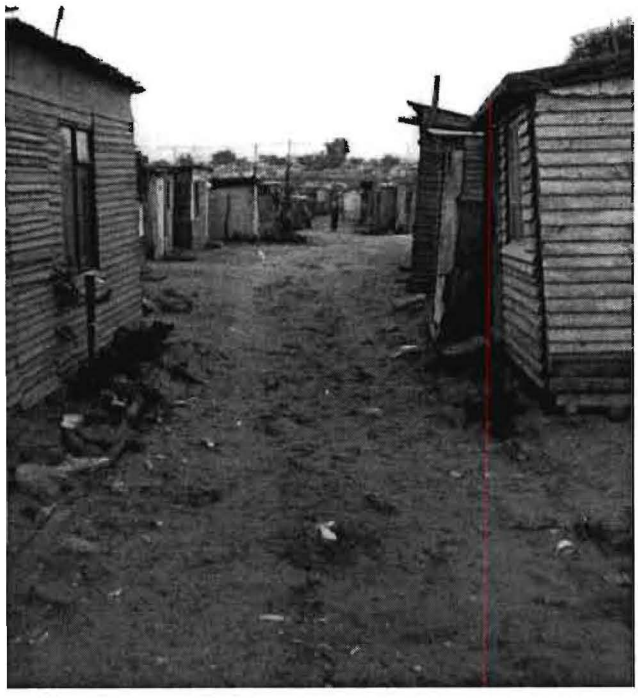
Through the interviews different styles of coping with the challenges of this setting were shared. Five main themes were inductively derived from this data in relation to nurses' feelings about working in an informal settlement: nurses felt powerless in the face of the overwhelming level of poverty; they perceived their work as valuable and worthwhile; they felt an enormous emotional involvement with patients and the community; some reached a stage of feeling like they belonged in the community; but the high mobility of patients in an informal settlement was a source of frustration for the nurses. Exposure to traditional methods of healing was also common in this setting.

The relationship between social and economic problems and disease was recognised and accorded prominence within the PHC approach. Community nurses are thus expected to be aware of the social and environmental problems experienced by their patients. All of the nurses interviewed indicated that through their daily consultations with patients they confront a range of social problems. Like many other South African informal settlements, the residents of Brown's Farm and Masiphumelele experience poor social conditions caused by lack of water supply and sanitation, refuse removal, and overcrowded housing. Indeed, illness and disease caused partly by problems of poverty, unemployment, overcrowding, adverse environmental conditions, poor levels of education and violence constitute the daily workload of nurses in primary level settings.

For nurses, the overwhelming emotion was one of **powerlessness** and helplessness. Many felt that the environment that they were sending patients back to was an obstacle to their healing, and therefore felt that their efforts were useless. As one nurse described:

> " Here the people have actually got nothing. You know it's very difficult. As you do a TB client, perhaps you'll cure him. But eventually he'll come back as a re-treatment because he's going back to that situation. No food, no clothes, the bad place he stays in. So we do not actually see to the problem. The problem is a proper house, money, food or whatever. So you're sitting with the patient and you're sitting with the same one again each time". *(RN1)*

This reflects the way in which nurses judge their efficacy - by concrete measurements such as the number of patients they have 'cured' or the disease statistics of the area, rather than by less measurable means such as caring or whether they have spent time with clients. Nurses have been socialised into being task-oriented practitioners who are able to account for their work through concrete measurable means. They are actually in a double bind. They have to process scores of patients through a system, yet this system is so impersonal that it turns patients into numbers. It leaves no time for meaningful communication which would allow patients and nurses to get to know each other's concerns. The nurse feels like a failure when a patient is not cured, and cannot receive reward from other interventions such as helping a patient to understand the disease process or to cope better with it.



"...he's going back to that situation."

Illustration 8: **The typical conditions in a peri-urban informal settlement**

Another nurse explains her feelings around working in an informal settlement:

> "Sometimes it's depressing. It is depressing: the conditions; the environment. Sometimes it's not just the clinic as such, but the whole area. Because the people who come here they have problems you can't solve. Sometimes you've got to listen and you feel sad because it's just listening - and it ends there". *(RN5)*

This nurse felt real sadness about the limits of her practice in this setting, but it is interesting to see how she doesn't consider listening to be an important part of her overall interaction with the patient.

Having to face what they consider to be powerlessness and all the facets which this encompasses, also makes the nurses feel needed. They see the environment as being hopeless and realise that the service which they provide is v**aluable and worthwhile**. This also provides some form of fulfillment for the nurses in the sense that they are providing something for people who have few resources. As these nurses describe:

> "...But the first time in a squatter camp, and I'm really enjoying it. It's hard work but you get a lot of joy out of it, because you can see what you're really doing is helping. And these people do need it". *(RN1)*

> "But you do get satisfaction from what you are doing. These people are illiterate most of them. At least we're doing something for them, and they know that and they do appreciate it. Just making a difference in their lives, we do have that sense of satisfaction". *(FG2)*

Feeling needed can also be a motivating factor in choosing community-based as opposed to hospital work:

> "I decided to work here as a community nurse because I like to work with the community. Share information with them and help those who are suffering. Because you see black people are sometimes illiterate and so they need to be educated...so we see our people suffering, so I decided to come and help those who don't know what to do". *(RN4)*

Nurses perceive their work to be valuable and worthwhile because they see it as being different from what nurses in a hospital setting provide, and they see it as 'making a difference' to those who receive their services.

With reference to being needed, one nurse shared about the difficult decision which she had to make when over the space of six months the other three nurses at the clinic either resigned or were moved. She found herself on her own with three new staff, feeling very despondent and ready to leave:

> "...and I went and sat down and I thought about it and I said: no, if I also go there's nobody who knows the setup, who knows the patients. Let me stay and help them along. But now I think I couldn't go anymore because they actually need you here." *(RN1)*

This nurse had a very difficult decision to make which led her to examine the meaning of this work for her. Her decision to stay was based on the belief that she was needed both by the patients and the new staff who needed orientation to a different work environment. She clearly put her own feelings of abandonment and despondency aside, as her sense of being needed was a far more powerful emotion.

Another nurse from the same clinic shared how unhappy she was at work and was also grappling with the thought of leaving. Her ultimate decision to stay was also based on a feeling of not wanting to desert people who needed her:

> "But the one thing I'm not going to do, I'm not going to leave my people". *(RN2)*

The same nurse continued to say:

> "You are here to serve the people and accept the people in spite of everything". *(RN2)*

This nurse believed that her priority was the people and not her own feelings of unhappiness. She decided to stay at this clinic despite the difficulties and emotional strain which she experienced.

Facing the sometimes depressing socio-economic conditions in an informal settlement evokes strong **emotional reactions** in some nurses. Many of the nurses shared with me an experience when they were overcome with emotions at having to confront the reality of everyday life in an informal settlement:

> "Because I go into these people's houses and really sometimes I want to cry when I come out. And that is what's happening at home". *(RN1)*

Sometimes getting 'emotionally involved' is regarded as being inappropriate by colleagues. The following nurse explained to me why she felt it was important to have an emotional attachment with patients:

> "People say sometimes that you put your own personal feelings in between, but I don't think it's true. If you are that kind of person you will just go all the way to help a client". *(RN1)*

Sometimes work does not end when you leave the environment. A few nurses described disturbing events which had plagued them at home after the day at work. These were often related to times when the nurse felt unsure about her actions:

> "You feel bad. And at the end of the day you keep on asking yourself: did I do the right thing or did I help them?...then you think how those people must feel just at that moment". *(RN5)*

One nurse, a remarkable woman, told me of how she worked in a clinic without a roofed waiting room. She had struggled with the moral dilemma of wanting to care for people, yet working in a physical environment which would not allow this:

> "You would feel sad for those people sitting here in the rain and everything - and we're sitting in the covered area. We say we are serving them but we are leaving them in the rain in whatever condition". *(RN5)*

This clinic was situated in two containers with no waiting room. The patients would stand in a queue outside while waiting to see the doctor. This sister raised her concerns with the Provincial Authority but was told that the clinic had not been planned for and that there was no money for extensions. Not deterred by this response she sought other avenues and obtained funding to build a covered waiting room from a source in the United States. What prompted that nurse to act beyond the scope of what she is required to do, and to make a difference for a community in which she does not even live? Perhaps it is the challenge of working in an informal settlement which provides opportunities such as this for some people who have the courage to make changes and be innovative.

A similar feeling of wanting to go beyond what is required of them, was found in another clinic:

> "Like when it's TB day we go all out. We'll go to each place and find something. We treat our patients and we go into their houses. If they haven't got paraffin money, let us club together and make them something". *(RN1)*

Many black nurses referred to their patients as 'our people' and seemed to express a **feeling of belonging** and an awareness of the socio-economic circumstances of people living in informal settlements despite none of them actually living there themselves. As one nurse stated:

> "Because our people, the community needs us." *(RN2)*

This phenomenon of belonging was examined further in both focus groups. The CHWs felt that nurses 'belonged' to the clinic because they considered it theirs and felt proud of this space. The CHWs were adamant that nurses should not work in a community where they do not live as they would not know the people there and therefore would not know how to help them. The following quote is the response of a CHW when asked about this phenomenon in a focus group:

> "No, it was just their pride, because it doesn't go like that. You cannot say that if I'm working here and I'm not staying here, that this is my clinic and for my people, though I don't belong to this community. Who do I know here while I'm not staying here? I cannot work in Brown's Farm because I don't stay in Brown's Farm. Yes, I know the CHWs, but I don't know how it works in the community. You see, it would be difficult for me. So they are proud of the fact that even if there are no people in the clinic, they're going to pay. They are going to get their salaries. So it's a pain to us. That is why we are there to go around in the community and look for sicknesses or any other problems that the community has got. And then come back to whatever resources are there to help with that problem". *(FG1)*

The response from the nurses' focus group, was two-fold. Firstly, the nurses explained their reference to patients as 'our people' was related to a sense of wanting to give back what they have learnt to people who are less fortunate than themselves, and secondly, it was related to the nurses being black and working in a black community. 'Our people' refers to belonging to the same race and cultural group. As the following nurses explain:

"It's her people in the sense that, even if I live in Guguletu, the people at Brown's Farm are still my people because I have a responsibility of helping them. Because most of them, they are not educated, so I should have a responsibility of helping them out". *(FG2)*

"My people can mean many things, because you don't see white sisters coming to work here, of course, because of the violence and other things. But without violence, some of them don't care because it's the black people. When we say 'my people' we are thinking of the black people who are suffering. Imagine if we could all say that we don't want to work here anymore! Who can then help the people around this place?" *(FG2)*

As none of the nurses in this study actually live in the community where they work, they spoke about having to earn the trust of the people. Achieving this level of trust centred around the nurses' attitude towards the patients and their acceptance of them. Once the nurses felt trusted they began to consider themselves as **part of the community**. As one nurse described:

"But now that I've worked in the community, I prefer it because we are with the people. You know we are down there with them. And communities need to be developed and also, the people don't know many things. So at least, when you're working in the community, you become part of that community - even if you don't stay in the community. They let you know their problems. They treat you like a mother and a sister. If you are OK with the people, then they come with their problems and you address them. So it's like working at home". *(RN2)*

Another nurse who felt that she was beginning to gain acceptance within the community said:

"What I find about this community, if you help them along the way, you come in with the car, and they will wave to you and hello and so on. And they will always tell the next person: "that one helped me" and that gives you a bit of satisfaction and joy". *(RN1)*

Some nurses felt that in order to develop a trusting relationship with clients it was important to know what it is to be poor:

"Let me put it like this: when I was a little child, we lived in what I would think was a squatter camp...we tried our best you know...but we didn't have toilets...I think where we were thirty years ago or more, is where these people are now. And it's just the process". *(RN7)*

Another nurse went further to say:

> "Like I grew up really very poor. And if you don't know that concept *(what it is to be poor)* you won't help them. You must know what people go through I think. If you know their feelings then you know what it is to be like them and then you will work very, very well with them". *(RN1)*

One of the **frustrating** aspects about working in an informal settlement for the nurses is the **high mobility** of the population. They find it incredibly difficult to keep track of patients, especially those who require follow-up such as people with TB. Added to the problem of the influx of people, the infrastructure of roads and house numbers is often not well established, making it even more time-consuming and laborious to find people. The nurses rely heavily on the CHWs to help them find patients. As one nurse accounted:

> "The problem is due to the squatter area, people move from this area to another area - and sometimes it's difficult to trace them... another thing due to this urbanisation people move from the rural areas to come here...so it's really a problem - because people are moving...I mean if there is a company evicting houses in that certain area, then these people must demolish their shacks to go to another site. Then sometimes it's difficult to trace them". *(RN6)*

The influx of people can sometimes be a source of frustration for nurses as their daily patient load increases without an accompanying increase in staff. As one nurse recounted:

> "The patients are growing in number everyday and you can't control the numbers here because overnight you've got five people moving into the area. There's no control over it". *(RN5)*

Working in informal settlements also exposes nurses to alternative forms of medicine especially **traditional healing**. This can be both enlightening and threatening for nurses. One of the nurses I interviewed has had much experience with rural health care as she was trained in another African country while in exile. Her feelings on the matter are:

> "If you deal with people in the rural areas, you've got to have a certain approach for the people in the rural areas. Because they have certain norms and traditions binding them, so you've got to understand the norms of a particular community. That is why in the community health they always talk about community involvement. They mean those people must be involved". *(RN3)*

The same nurse continued to say:

> "When you do community health you will come across traditional healers. People in the communities have their own beliefs". *(RN3)*

There is an obvious tone in the above quote of a separation between 'us' and 'them'. People in the community are seen as being separate from the nurses and they do not want to identify with their beliefs. This is a interesting contrast to their previous feelings of belonging and perceptions of their patients as 'our people'.

5.1.2 Experiences of CHWs

The CHWs' experience of working in an informal settlement is largely influenced by their status as residents. Not surprisingly, their view of the environment is different from that of the nurses who work there. A situation which the nurses may regard as hopeless is often seen by the CHWs as challenging.

With the high level of poverty and its related effects, the focus of the CHWs is evidently broad, as physical needs are usually not the priority health needs of families. Their work involves a large amount of networking and collaboration with other organisations within a community in order for them to be able to refer patients to the appropriate resources. CHWs are frequently also respected leaders within community structures such as health committees or residents committees. They are therefore well known by community members and are knowledgeable about social processes and organisational structures occurring within the community.

The following CHW captures the essence of their role:

> "Just to uplift the standard of health in this community". *(CHW8)*

CHWs see the **focus of their work** as being broader than curative. For them, there is a far more pressing need for education, advocacy and skills development. As one CHW stated:

> "What is important to us is to educate the people, more than curing the people". *(CHW1)*

"...because we have to go from door to door."

Illustration 9: **CHWs visiting a community member**

The CHWs are conscious of the high level of unemployment and the cycle of poverty which it causes. They are determined, however, that people should not rely on others to rescue them, rather that they should learn to be self-reliant. This is where their commitment to **skills development** is particularly evident:

> "So we also do advice about vegetables for the people to try and sell it themselves. Not to depend on other people... because they are not working themselves. But you are supposed to eat nutritious food". *(CHW2)*

It is evident that there are few limits to what CHWs will do for people in their community. During a home visit they will do their best to manage whatever problems they encounter with grace and confidence:

> "Yes, because we have to go from door to door. Sometimes you find people in their houses and sometimes two days sleeping in the bed...another one is staying alone in the shelter. And he says: "From yesterday I'm sleeping here because I'm sick. We haven't got fresh water here". *(CHW4)*

They were astounded by this situation but set about helping the man and making him comfortable. She describes how they went about caring for this man:

> "And then you throw away the old water and then you go fetch the fresh water and then you give him some water". *(CHW4)*

A situation such as this truly highlights the vital role which is fulfilled by CHWs in contexts of extreme poverty and few resources. People who are available always, who visit house to house and who know the appropriate referral channel to get people to a health facility. 'Going beyond the call of duty' is what characterizes the CHW role. They will do whatever is needed to assist a person. Even if this requires giving away some of their own limited resources, be it food or money:

> "...so I hear to their daughter her mother is having a stroke now in Transkei...so when she arrived they called me...so I took her to crossroads...that lady didn't have money for the taxi so I take my money for the taxi...so that lady also had nothing to eat so I went to my house to get mielie meal, sugar, coffee". *(CHW2)*

Their work incorporates a wide spectrum of activities and they believe strongly in the importance of **networking** and collaboration. They have a vested interest in improving the health of the community in which they work, as it is also their home, and they will therefore reap the benefits of their efforts.

The involvement which CHWs have with other resources and the networks they form, is illustrated in the following accounts:

> "We also deal with people who are being abused. For instance, we've already formed a network together with the child care unit and with the police station". *(CHW7)*

> "And we also visit other resources like schools and churches to do workshops and teach people, I mean the common diseases like STDs and TB also". *(CHW7)*

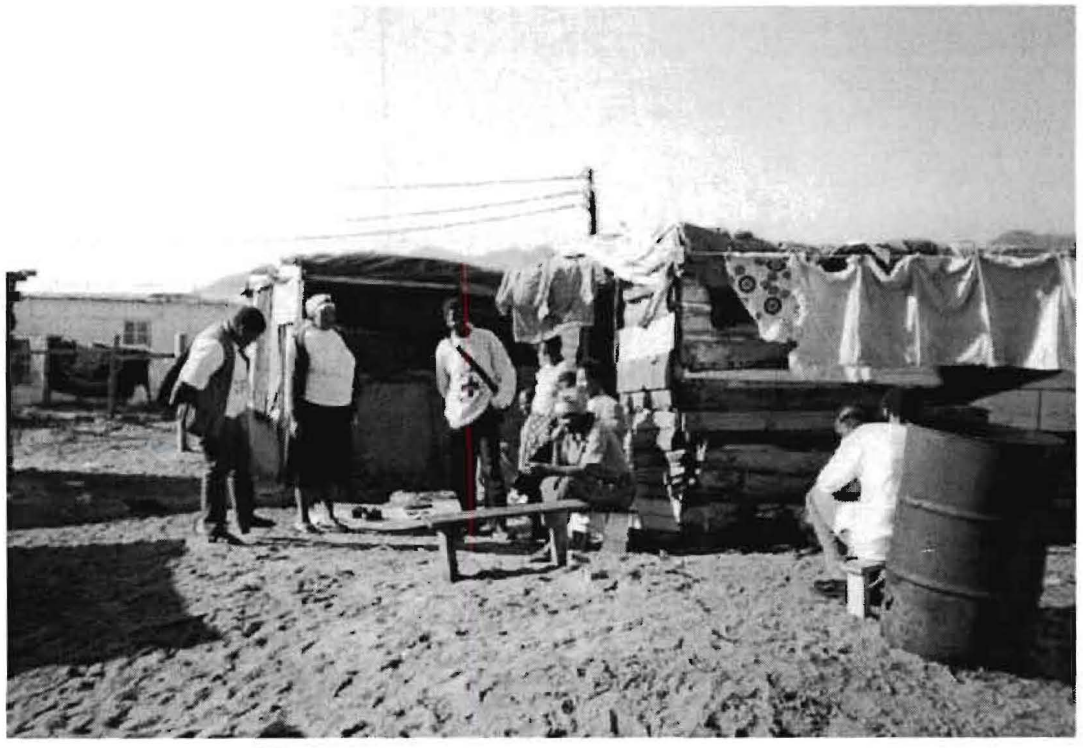
> "And we are trying to work in co-operation to each and every resource around this community in order to promote collaboration". *(CHW7)*

"The most important thing is: it involves network. That means to work with other resources". *(CHW8)*

Observation indicates that CHWs often assume a key position in the **leadership** structure of a community - they are highly respected, and trusted with decision making at a senior community level. They take their role as advocates very seriously, and are usually determined vehicles of change in the community. The following CHW explained her advocacy role like this:

"We are also bringing the people direction, so that is advocacy, if ever there is a person who doesn't know". *(CHW7)*

It is clear that the work of the CHWs in this study is multi-faceted. They design their interventions around the priorities in the community and have a flexible approach. They are uniquely situated to act as a bridge between the community and the health system as it is evident that they are available and trusted by those with whom they live.



"We are also bringing the people direction..."

Illustration 10: **CHWs discussing health issues with a family**

5.2 THE PROCESS OF THE RELATIONSHIP BETWEEN CHWS AND NURSES

From the interviews, observation and field notes it became clear that the relationship between CHWs and nurses can be described as a process which occurs when a CHW project is initiated in a community. The clinic is the initial point of contact which CHWs need to establish when beginning work. It is also their major referral centre and therefore positive relations and respect between these two groups is essential for effective patient management. Certain fears, perceptions and expectations begin to form within both the nurses and the CHWs when a new project is established and these are explored further in three phases which emerged from the analysis of data.

The process of the relationship between nurses and CHWs appears to follow three phases:

- **The initiation phase:** Nurses are unsure of the CHW role; CHWs experience being undermined.
- **Beginning to understand each other**: Nurses begin to understand the CHW role; CHWs are used as an extra pair of hands.
- **Uneasy co-operation**: Nurses begin to value CHWs; CHWs look up to nurses as role models and mentors.

5.2.1 The Initiation Phase

This phase is characterised by the nurses being unsure of the role of CHWs and regarding them as a threat. The CHWs felt an overwhelming sense of being undermined and not recognised. Nurses at this stage consider CHWs as extra pressure rather than a help to them, and CHWs experience their relationship with the nurses as being unpredictable.

NURSES	CHWs
Are unsure of the CHW role	Feel undermined
Feel threatened	Experience self doubt and low morale
Regard CHWs as causing extra pressure	Consider nurses to be unpredictable

It is evident that at the most vital time when the two CHW projects in this study were established, there was confusion over whether the nurses or the CHWs should initiate introductions. As a result the CHWs started working without first sitting down and explaining their role to the nurses. They worked side by side without working together:

"But all in all we didn't sit down and say who we were one by one. And yet we just started our work and then we worked together you know - without informing each other. But we've been trying to work together. And yes, maybe there were problems, but they were minor problems. I mean things that you should. I mean experience...that must stay in our minds". *(CHW7)*

It seems as if these CHWs began their liaison with the clinic in a very haphazard and uncoordinated fashion. They were serving the same community yet were unclear about each other's roles. This CHW felt that the difficulties which they experienced with the nurses were related to their inexperience as CHWs. The following account from a CHW explains how the conflict with the nurses centred around minor issues such as not being able to find one of them when they were needed, and how this is directly related to the lack of explanations when the project was started:

"They will send someone to look for a patient and they didn't come with a reply. Or they wanted one of us and couldn't find us. Because they didn't come to us and sit with us and hear from us what we are really doing and how we are working. So it has been a confusion from the start, that we should have called them or maybe, they should have called us and ask what the main job is that we are doing". *(CHW5)*

With regard to not knowing each other, one sister who works for an NGO explained her understanding of why the CHWs experience conflict with the nurses:

"I think it's based on the role. The clashes are because of not understanding the role. It's very important to understand the role of the CHW and the role of the nurse. It's not a duplication. You know some of them *(nurses)* have never been to the communities. They were saying: "We don't need them! They don't know what they're doing!" Because they don't know the work of the CHW. Because in a clinic, you don't only look at curative measure as a sister in charge of a clinic". *(RN3)*

This particular sister has only ever worked in the NGO health sector, and portrays a very different perspective on primary level care than the nurses working in government clinics. The same sister explains a common situation where a CHW has referred a patient to the clinic and the sisters don't accept the CHW referral letter:

"And some nurses will say: "No, I don't know them. That is why I didn't accept their letter. No one told me about them." But this time they are coming with a problem, you have to look at the problem first, and then you investigate who they are at a later stage. You don't chase the patient with the letter and clash with the CHW". *(RN3)*

The nurse described in the above quotation illustrates an example of the hierarchical system within which nurses function. This nurse seems more interested in finding out who the CHW was than in treating the patient, her primary concern. The following description is of a similar situation where the nurses did not want to accept a referral letter from a CHW:

"And here we are working in the same plot, but they do not recognise us. When we make a mistake, they make a show-off in front of the community. When we write a referral letter sometimes to *(another clinic)*, when the patient gives that letter to the sister, the sister just tears it up - and undermining us in front of the patients. So we were embarrassed with that". *(FG1)*

For the CHW, the referral letter is the major connection with the clinics. A rejection of this is a direct rejection of the CHWs and their efforts. Another CHW describes her experience of a similar situation:

"And we also refer to them. So when you write a letter for the patient they ask the patient: "What is a CHW? Who is that person? Why is he referring you?" And they don't take our letters". *(CHW2)*

These are clear indications of the struggle for recognition which characterises the experience of CHWs in the initial phase. Situations such as the ones described above lead to feelings of worthlessness in CHWs who are striving to help their communities, yet are facing such resistance from the very people with whom they should be co-operating. The following account describes the difficulties experienced by a CHW when she first started working:

"When we started working it was too difficult because...they didn't like us...they didn't recognise us...But now it's much better. We are working hand in hand with the clinics". *(CHW1)*

Another CHW describes an instance when she felt undermined by the nurses:

"Oh, we were upset. And they lower our morals *(morale)*. And we became confused because we didn't know which is right and which is wrong - although we were told and taught what we must do". *(CHW8)*

The above account illustrates how when the CHWs feel undermined by nurses, it results in self doubt and low morale.

As has been described in the literature review, the legislation relating to CHWs is both vague and contradicting, and the initial training which they undertake for twelve weeks is not accredited within the National Qualifications Framework. This further exacerbates the lack of understanding which nurses have about CHWs. As one nurse describes:

> "I think, as you know we were trained-and we do our training all the years. And here these people come who were training for a short while, and all the things that we had to have education for and certificates for and pay the council, they are actually doing part of this. Not everything but part of it. And that is what most of our people *(nurses)* don't understand. They think that they are taking our space and our work out of our hands. But it's not that. They're just trying to make it easier for us. If people could see that they're making it easier for us, they won't work against them". *(RN1)*

CHWs experience the nurses' lack of knowledge about their training as a major barrier to establishing relationships with them. As one CHW described:

> "I don't know whether they undermine us or what, but we had problems. They didn't want to accept us because they said we have basic education. So we are not professionals. I don't know whether they think about that". *(CHW8)*

The sentiments described above represent a widespread notion amongst CHWs of 'not belonging'. They work within the health sector providing an essential service to communities which are under-resourced and rely heavily on NGO initiatives, yet they are constantly embattled in a struggle for recognition and acknowledgement. One CHW captured this struggle most vividly:

> "We are always standing on the platform of sorrow... waiting for that... if government would recognise us too". *(CHW1)*

With regard to National Department of Health recognition of CHWs, as has been described before, the legislation around CHWs is unclear. CHWs are aware that they are not acknowledged or recognised at this level and this is a source of much distress for them. The following CHW expressed her feelings about not being recognised:

"A little bit painful because we are working twenty-four hours. We are struggling with the people. I feel it's very painful that the government didn't recognise the CHWs". *(CHW3)*

The above account illuminates the deep hurt felt by CHWs. They are dedicated to helping their communities and work long hours, yet they receive no acknowledgement for the vital contribution which they make to the health system.

The sheer hurt and anguish which CHWs experience during this initial phase is very disheartening for them. Having just completed training, with enthusiasm and vision CHWs begin to introduce themselves to all the social organisations in the community (churches, schools, health committee etc.). The response which they receive from nurses often creates such a setback for new CHWs that some remain pessimistic and lose hope of ever establishing a positive relationship with these health professionals.

"Firstly, they undermine us. They didn't want to accept CHWs because we didn't attend the colleges they attended. I think it's because of that. And they think that we have little knowledge than them. I think that's the main problem. Or they didn't want CHWs at all". *(CHW8)*

The following CHW describes an incident when a decision of hers was undermined by a nurse. She describes how her intellect was questioned by the nurse:

"And then it came that the SPM *(South Peninsula Municipality)* doesn't want the clinic cars to take people to the hospital, except for the emergencies. And then when we ask for the ambulance to come, they just say that we mustn't call the ambulance just for nothing, you must call it for emergencies. Although we are calling the ambulance for emergencies...I mean we are people and we've got minds to think". *(CHW5)*

The following CHW describes the confusion which she experienced when starting work. She found that it was quite daunting and that the lack of clarity around their role lead to what she experienced as jealousy from the nurses:

"Other than that the difficult times were that we didn't understand each other. And that each person has got his personality, and that he's going to be looked by that. So sometimes that makes a jealousy. But I can do what he or she does - as group at work. But on the other hand, we cannot be the same". *(CHW5)*

The unrecognised training of the CHW leads to much misunderstanding between nurse and CHWs. The nurses are unclear about the CHW scope of practice, subjects which have been covered in training, and their role within the health team. As described above, in many instances the lack of understanding of the CHW role leads nurses to regard CHWs as a threat to their work. As one CHW recounted:

> "It was very difficult because the government staff they don't know us. They don't know what is a CHW and what is their work. Or they think about us as people who are taking their work". *(CHW2)*

A nurse who has been working with CHWs for three years explained:

> "Is it not because they are working just serving the same community?...Maybe some people will ...but I don't think that they should be a threat to them". *(RN5)*

This nurse acknowledges that nurses could see the CHW as a threat but for herself, over the three years that she has been working with them, she has clarified their different roles. This indicates a progression in the relationship over time, from feeling threatened to understanding the CHWs' role.

Another nurse explained how a response by a nurse of feeling threatened, is not justified. She feels that it relates to nurses' own insecurities - that a nurse who is already unsure of herself will not be able to deal with a CHW encroaching on her space:

> "I don't see a clash because you cannot compare a professional nurse or sister with a CHW. Because their role is limited. So once as a nurse you feel that you are clashing with the CHW, there is something wrong with you. Because the role of a CHW will never be the role of a nurse. Those are two different things. So it's a lack of understanding sometimes. People don't understand". *(RN3)*

A sister who had been working in a community health centre for six years seemed very unsure when asked about her understanding of CHWs:

> "You see I'm not sure because they are being paid by that money from overseas. They are not under government. You see I'm not sure. I think so". *(RN4)*

Some nurses experience having CHWs in the area as extra pressure. They don't consider them as part of the health team but rather as a burden on them and something which is not found in most clinics. As one nurse described:

> "Also having voluntary workers, all extra people that aren't in other clinics. You know which is extra responsibility, extra pressure". *(RN7)*

On many occasions, CHWs describe the relationship with nurses as unpredictable. They are never really sure where they stand and feel like they have to 'tread lightly' when they are around them. When asked to describe his relationship with the nurses, one CHW said:

> "It's fine. It's good. Sometimes on and off, because sometimes it's bad and sometimes it's good. Because the nurses are changed and sometimes you feel: today this nurse is no good, and tomorrow she's good sometimes". *(CHW4)*

Another CHW expressed similar sentiments around the unpredictable nature of the relationship:

> "I can say that on the one hand they do and on the other hand they don't. Because sometimes they are cross with us, sometimes they are good with us. So I'm not sure which side they are on". *(CHW5)*

This initial stage is characterised by confusion on both sides. Nurses encounter a new group of people who are seemingly doing work which is similar to theirs, they may never have encountered them before, and are unclear about their training and function. Their immediate reaction seems to be to feel threatened and to protect themselves by undermining the CHWs. CHWs who are eager to establish a relationship and to learn from the nurses, are suddenly faced with criticism and disapproval. They feel worthless and begin to question where they belong in the health system. These insecurities are exacerbated by the contradicting and unclear legislation pertaining to them.

5.2.2 Beginning to Understand Each Other

During this phase CHWs and nurses begin to understand each other and the conflicts appear to be less frequent. The nurses have had time to work with the CHWs and to discover that they have a good knowledge base and are reliable. This leads the nurses to use CHWs as an extra pair of hands in the clinic. The general feeling is that the CHWs are needed and that nurses regard them as being reliable. The CHWs are considered valuable by the nurses for the work that they do for the clinic, making their own job easier, and not the role which they play in the community.

The CHWs undergo an internal struggle, as they dream of becoming nurses and have often chosen to become CHWs because they did not have the financial or academic resources to train as nurses. When faced with the options of working in the clinic rather than performing home visits which is their major activity, they experience some confusion over their loyalties - they want to work in the clinic to feel like nurses, yet they know that their role is to be in the community. They also see nurses as holding the power and are more likely to obey them than to stand up for what they believe.

During this phase the CHWs also realise the fullness of their role in the community and the importance of living there. They often compare themselves to nurses who don't live in the community. They are trusted by the community and assist people because they want to help their community. The nurses, as part of a profession, assist patients because they have an ethical responsibility to do so. They describe their interactions with patients as a duty. The CHWs are sensitive to the cultural factors which influence people in their community to seek health care.

During this phase there is also a marked increase in utilisation of the clinic. CHWs are now known by their community and they set about motivating people to attend the clinic. CHWs worry that the reason why their relationship with nurses is so difficult, is because they 'bring them more work'. Some nurses start to see the value in this as they begin to consider CHWs as the link between themselves and the community.

NURSES	CHWs
Realise that CHWs have a good knowledge base and are reliable	Experience internal struggles because they dream of becoming nurses
Start using CHWs as an extra pair of hands in the clinic	Are confused over loyalties: clinic vs project
Don't live in the community where they work	Regard nurses as powerful
Have an ethical responsibility to treat patients	Realise the importance of their role in the community - living there
Notice the increase in utilisation of the clinic	Are trusted by community members
Experience cultural and language barriers between themselves and their clients	Are sensitive to cultural influences on health and illness
	Recognise an increase in utilisation of the clinic as a result of their efforts
	Consider themselves to be a link between the community and the health services

After the first few months of adjusting to the presence of CHWs, nurses begin to realise their value. The following nurse expresses the usefulness of CHWs in recalling patients with TB who have not collected their medication:

> "Because they know the areas. When someone was defaulting, I was using them to go and recall them for me". *(RN8)*

In the description above it is important to note that the emphasis for this nurse was on getting the patient to take his tablets. She did not ask the CHW to talk to the man to find out why he was not taking them, she/he simply had to fetch the person. This illustrates the manner in which nurses use CHWs as an extra pair of hands to fetch and carry things, rather than drawing on their skills in home visiting. The following nurse expresses a desire to involve CHWs more in the administration of the clinic:

> "For me, I feel still the CHWs are under-utilised. What is wrong with...I mean, like especially when it's a bright girl you know. Or I want to pack the dispensary right. Why can't I ask this girl to come and give me a hand. "You count and I will write down". Things like that". *(RN7)*

The following nurse echoes the same reasoning that CHWs are there to fetch patients who do not attend the clinic. Nurses now start to see this as a great help to them:

> "The way they work, you know they are the people who run after defaulters. Give treatment. Bring patients with problems to us. They do a great job". *(RN2)*

During this phase the nurses realise that the CHWs are reliable and they can trust them to carry out tasks. As one nurse expressed:

> "It is quite nice actually. Because if now I can't do something, I can really depend on them. And call one of them and say: "Can you please do this for me?" And at least I know it will be done. And they will come with a report back: "This is what we do and this is what the lady says". So it's very helpful. I find it very, very helpful...so I can go on with my work". *(RN1)*

However the choice of whether or not to use CHWs and to work with them, is ultimately the nurse's as the professional, and they make this power known to the CHWs. As one nurse stated:

> "Yes, we can use them if we want to". *(RN6)*

One particular nurse had worked with CHWs in another setting where they were treated like nurses and had the same working hours as nurses:

> "They're getting on duty together and they're going off duty together". *(RN8)*

This completely negates the major purpose of CHWs, which is to be available to their community at all times. The following nurse who works for an NGO explains her feelings around the misuse of CHWs:

> "Once you don't know the role of the CHW you will tell him to clean the floors because you don't know his or her role. Because a CHW is not supposed to be in a clinic in the first place. A CHW is in the clinic because you've planned together with them that on such and such a day you are going to do reports. You are going to discuss the problems of the community together". *(RN3)*

This nurse highlights her ideal of the relationship of mutual respect which could exist between nurses and CHWs, where nurses value them because they are the authority on community needs, and consult with them on decisions regarding the health services in a particular community.

However CHWs are increasingly being encouraged to take on greater responsibilities within the clinic, due to their skills and knowledge on which the nurses have come to rely. In one of the clinics during 1999 there were severe staff shortages as two nurses resigned in the same month and these posts were not filled immediately. The CHWs were asked to work in the clinic to assist with the distribution of TB medication. One of the CHWs describes how this decision was made:

> "And now we are in the process to select someone to go inside the clinic and work together with the nurses to deal with TB". *(CHW7)*

In circumstances of severe staff shortage within the clinics, CHWs are asked to go and assist with treatments inside the clinic. As one nurse explains:

> "For instance, here at the health centre, we are short staffed. Sometimes there will be only the two nurses staffing that clinic. And we've had days when the people from the CHWs would come and work in the dressing room". *(FG2)*

This description highlights the irony that CHWs are in some cases used as nursing workforce within the clinics, yet they are not even recognised by the National Department of Health for the work which they do as CHWs. This leads to much confusion amongst CHWs who begin to question where they 'belong':

> "But I am a nurse, but not professionally as a CHW because I can cope with some of the sicknesses". *(CHW5)*

This CHW realises that most of what she does is actually 'nurses' work'. But because CHWs are not recognised as a category of health personnel, they have no professional body with which to identify themselves.

In one clinic there was a situation where one of the CHWs who was regarded by the nurses as being intelligent and having great potential, was offered a job as a clerk in the clinic. The CHW thought that this was a great opportunity and was considering accepting the offer. She did not,

however, inform either the other CHWs working with her, or her co-ordinators as her loyalties were torn between the clinic and the CHW project. The job was, in fact, only an eighteen month contract position which required fewer skills than are needed for a CHW post. However, it had a larger salary, which was the principal motivating factor for her wanting the job. She describes her feelings around this experience:

> "The types of conflict that I had to deal with are...the one is that the clinic offered me a job and it was a very bad thing - that the clinic had done it wrong. I just wanted it to stop, not to be offered a job again". *(CHW5)*

Here reference to 'the clinic doing it wrong' was what caused this CHW the most anguish. The nurse who was the area manager for this clinic had approached the CHW and offered her the job. This post was not advertised, nor were any interviews held. When some members of the community heard about this there was an uproar. The co-ordinators of the CHW project also approached the area manager and expressed their concerns about losing a CHW who had received extensive training and input, and who had only been working for six months in her CHW job. They also stressed the high unemployment level in the community and the unfairness of taking someone who was already employed and serving an important need in the community.

This example illustrates the lack of insight which this nurse had with regard to democratic processes and procedures of employee recruitment in under-resourced areas where employment is so valuable. After the members of the health committee complained about the lack of advertisements and interviews for this post, the CHW who had been offered the job was told that she would have to apply formally and undergo an interview process. This was a very painful experience for this CHW as she lost the respect of her fellow CHWs and was made to feel like an underhanded person by community members.

For CHWs their role can be very confusing at times due to the pressure from nurses, whom they regard as their seniors, to assist in the clinic or to carry out tasks for the nurses, and the pressure from their own project co-ordinators to visit a certain number of houses each month. It is also evident that many CHWs have a desire to become nurses, and so they are torn between fulfilling their role within the community, and having the opportunity to be like nurses in the clinic.

The following CHW expresses her wishes of becoming a nurse:

> "It was my dream. My dream. When I was younger I was dreaming of becoming a nurse. But things didn't go that way". *(CHW8)*

The following CHW believes strongly in the importance of an education and has been attending night school to complete her Matric. She too has a desire to become a nurse:

> "Maybe one day I can be a nurse because I want to continue with my studies. Because last year I was doing my studying at night. Now I want to continue with my studies and take a few more steps". *(CHW3)*

Financial constraints often prevented CHWs from undertaking nursing studies. As this CHW explains:

> "In fact from the lower classes at school, I thought I would be dealing with the sick people - that I would like to be a nurse. But then due to financial problems I couldn't make it". *(CHW5)*

During this phase of developing greater understanding between nurses and CHWs, CHWs also become more comfortable with their role within the community and the high expectations which community members have of them. CHWs are supposed to be available twenty-four hours a day. As they work in areas with few resources they are the ones who are called upon for any emergency requiring medical attention. CHWs experience this expectation differently. Some consider it an honour to be indispensable, while others feel that it robs them of personal time with their families or friends. The following CHW describes how she feels about having to always be available:

> "And the CHW is working for twenty-four hours per day. You can't say: I'm sleeping, I'm tired, I'm from doing a home visit. You're supposed to help the patient". *(CHW2)*

Being the only resource that people can turn to after hours also places a huge responsibility on the CHWs. Knowing that there is nowhere else for people to go, they make personal sacrifices in order to help people. The following CHW describes how she sometimes has to give up special time with her children in order to attend to people's problems:

"As a CHW you've got no chance to be a family. You know, from the clinic now I'm going to my house. Maybe my child from school, tell me about the school. There's someone coming to my house, but I'm also trying". *(CHW2)*

There is no sense of bitterness in this CHW's description. She knows what her work entails and tries her best to manage all her responsibilities. The work of the CHW, often places them in danger, especially during the night when they have to visit people's houses. The same CHW describes how vulnerable she feels when people knock on her door at night:

"As a CHW you're getting people at twelve/one o'clock at night, knock-knock. You can see outside there is a lot of crime. So when you hear someone is knocking at your door you are not sure that it is a patient. But you open the door. That's the only problem. But we are trying". *(CHW2)*

CHWs often compare themselves to nurses in terms of being available to the community. They justify their role by the fact that nurses don't have time to do home visits and that they are gone at four o'clock. As one CHW emphasised:

"Because we are there in the community and they *(nurses)* are not there. Especially at night and emergency times. And those people are sick at night and we are there to help those people". *(CHW1)*

Another CHW expressed similar feelings around the vital link which they form between the community and the health services:

"Nurses are not going to do home visits. They are just staying at the clinics. They are waiting and the people are supposed to come to them. But the CHWs they go house to house. And I don't think the nurses can do that work. But as a CHW we do it. We like it because we get more and more knowledge when we do home visits". *(CHW2)*

Another CHW explains the reasons why they are so necessary and gives examples of people who work or are disabled and can't get to the clinic:

"Because after four o'clock the clinic is closed. Then if she go to work and then come to us, or sometimes she is not walking very well, and then we are helping to give them the TB treatment at their house". *(CHW4)*

It is interesting to note the difference between how CHWs see their role and how the nurses see the role of the CHW. The CHWs emphasise the importance of their work because they are always available and are willing to help. The nurses feel that the CHWs are valuable because they can fetch patients for them and perform some tasks within the clinic.

CHWs also feel strongly that they should be recognised by the National Department of Health because of their availability and the vital after-hours service which they provide to communities which have no twenty-four hour clinics or hospitals. As one CHW reasons:

> "And it can be a success through the government because it's a big thing, that they go and find someone sick in the house. But from the nurse's side they don't go in. they just wait until someone who is sick has been brought to the clinic". *(CHW 5)*

"...they go and find someone sick in the house."

Illustration 11: **A CHW visiting a client in their home**

The significance of encounters within the home setting is often emphasised by CHWs. Apart from being a resident in the community where they work, CHWs are also trusted and respected. They are the ideal people to inform the community about health resources and attempt to dispel any fears or apprehensions about the formal health services. As one CHW explains:

"Even the people they go to our houses today. They're not scared and they are not confused. They know that there are CHWs and then they use us. Before they didn't know that there are other resources or what they must do when they encounter some problems". *(CHW8)*

The CHWs also serve as translators for clients that they accompany to the clinic as, especially in one clinic, the first Xhosa speaking nurse only started working there in mid 1999. The language barrier was another factor which deterred patients from attending the clinic. As one CHW from Masiphumelele describes:

"And the community know and trust us. And it's easy for them to communicate with us - simply because of the language. Most frequently I mean the sisters in the clinic the sisters are used to be white. So the people in this area are illiterate, so they are not educated. So they are shy to speak to whites you know. They are shy to speak English because they are not fluent". *(CHW7)*

Despite the barriers of lack of knowledge, language, and fears of the nurses, there are people who still choose not to utilise available health services because of cultural or religious beliefs. CHWs, as members of the communities in which they work, have much insight into the health-seeking behaviour of people in their community. Nurses, if they see a patient who is severely ill and has waited a week to come to the clinic, regard this as negligence and are extremely frustrated with the patient. As one nurse explains:

"Really the people will sit with that ulcers and make it worse and worse. And then when it makes a big hole, then they get only help. I think when the pain is too severe, they come to the clinic". *(RN1)*

The CHWs are aware of the process which needs to be followed before people consult Western medical advice, which is frequently the last option. The following CHW describes the 'privacy of illness' which is present in her community. When people are ill they "close the door". The neighbours and family are the first point of contact and in this instance they chose to call the CHW. Others may have chosen a traditional healer or religious minister:

"Because before there wasn't a CHW in our communities. And you got a lot of disease. The people don't come to the clinic to tell them they are sick of that and that. But the neighbours they come to you as a CHW :"Please go to that house because the owner of that house is sick", and they don't want to go to the clinic. They don't want to go to you as a CHW. So when she is sick they close the door. They can't open the door". *(CHW2)*

The process of consulting with family members when a person is making a decision regarding health care is described by the following CHW. The reluctance to approach the clinic is seen as being related to fear:

> "Now, with the sicknesses, I believe it's more to do with their fear, not a cultural problem. Because really with your cultural thing, you have to talk with the family first. And then once the family...if she thinks that the CHW can help them, then she comes to the CHW. There's no fear in that. But with the sicknesses, it's difficult for them to go to the clinic. So they are most afraid of the clinic". *(FG1)*

Talking about sensitive issues such as reproductive or sexual problems is also often done with the health workers before the person seeks help from the clinic. This may have been because of language problems and the threat to confidentiality with a translator. The health workers also run workshops about sensitive issues to attempt to encourage people to seek help if they experience symptoms of sexually transmitted diseases. The following CHW describes how clients confide in her about sensitive issues:

> "And then the other people they were very shy to talk about the STDs. But now when we do the workshop, they say CHWs are OK to us. They go to our houses or here in the container, to speak about the STD'. Even the men, a lot of men come to my house. And then they didn't say it as a secret, they told me exactly what was wrong". *(CHW6)*

Males with sexual problems often approach male CHWs to discuss these sensitive issues. They are able to go to the CHW's house which is private and no-one will know what their problems are. This is of vital importance to black men who find it extremely difficult to share this information with women, as that would place them in a vulnerable position and the woman in a more powerful one. As the following male CHW explains:

> "Sometimes the communities feel secure or private when they are attending us. Because if ever a person visited your house, that person thought that cannot be exposed. So there is no one who can know what that person has got...the patient has had the experience of a problem. Especially with problems like sexually transmitted diseases you know. They are able to come and visit our houses, because in our houses it's more confidential. A guy of my age and gender, he knows that he can visit me. Because people will think that he is just visiting me". *(FG1)*

A phenomenon which has been seen to occur when a CHW project is established in a community is an increase in utilisation of formal health services. This is largely because CHWs inform people about these services. This phenomenon is noted by both CHWs and nurses. CHWs often talk about the differences in clinic utilisation before and after they began working. They display pride in this marked difference, which is as a direct result of their efforts:

> "Because as a CHW we have to go to the community. That is why the clinic is full today. It's because of the CHWs. Because we encourage people from the community to go to the clinic. But before they were scared to go to the clinic". *(CHW8)*

The clinic as a community facility is a very important concept which CHWs attempt to bring across to their clients. They feel strongly that the clinic is there for the community and therefore it should serve the unique needs of each community rather than being a bureaucratic, inflexible organisation which is 'owned' by nurses:

> "And it also increased the number of people who attend the clinic. To make them aware that the clinic is here and that the clinic is working for the people. It's a clinic for the people you know". *(CHW7)*

CHWs often feel that one of the reasons why they struggle to develop a relationship with nurses, is because they bring them more work:

> "That is why they cannot cope with the CHWs. I've seen that. It's like we are bringing more work for them. They are not used to that. Before they were working less hours although they are at work because there are no people coming in". *(CHW5)*

Some nurses, on the contrary, value the effort of CHWs in motivating people to attend the clinic. They are aware of their limitations and the important link which the CHWs provide between themselves and the community:

> "Our clinic numbers have always been high but it's getting more and more. And I think they *(CHWs)* have also contributed a lot to this because they will find a patient at home and refer the patient to us. And a lot of people who stay in this place didn't know that there was a clinic. They see this building but they won't make inquiries as to what it is. And they go to these people, they always tell them "there is a clinic. You must take this baby there. If they didn't have the injections please go there". *(RN1)*

The above quote indicates a progression in the thinking of nurses during this intermediate phase. They move from seeing CHWs as an extra pair of hands for assisting them in the clinic, to seeing their true value as the link between their community and the health services.

This phase is characterised by nurses beginning to see the useful skills and knowledge which CHWs have. This leads them to start using CHWs as an extra pair of hands to perform tasks within the clinic. CHWs are keen to assist in the clinic as many of them desire to become nurses. This often leads to a conflict of loyalties as the CHWs are torn between their responsibilities to the project and their desire to be like nurses. They also learn that nurses hold the power within this relationship as they can choose whether or not to involve the CHWs in the clinic.

As they become known and trusted within their communities, CHWs also begin to realise the importance of their work and the vital need for people such as themselves who are available always, and who engage with families about health issues within their homes. Being known by the community and encouraging people to use the available health services, also results in an increase in patient numbers at the clinics. CHWs fear that the increase in work load which they create is the reason why nurses struggle to accept them. The nurses on the contrary, value the efforts of the CHWs, and begin to appreciate the link which they provide between themselves and the community.

5.2.3 Uneasy Co-Operation

During this third phase the nurses begin to regard the CHWs as their link with the community, both in terms of knowing the area and the people, and in terms of language difficulties. None of the nurses in these three clinics lives in the area where they work and they recognise this as a barrier to their full understanding of the context in which they work.

The nurses value the CHWs for being 'there when they are not' and this appears to provide some sort of comfort and reassurance for them. They also recognise the role of NGOs in the health sector and the vital gap which they fulfill in under-resourced communities.

The nurses have by now spent enough time with the CHWs to realise that they have extensive knowledge, and that they are reliable and trustworthy. Some nurses reach the stage of understanding the true role of the CHW within the community and they are allowed to perform this work without being given inappropriate tasks to perform in the clinic.

CHWs, having been through the battle of gaining recognition and respect from the nurses, now look up to them as mentors as teachers. They realise that nurses have a lot of knowledge from which they can benefit. Some nurses engage with this and do teach the CHWs, but this is often done in a punitive manner when the CHWs have done something wrong and need correcting.

NURSES	CHWs
Regard CHWs as their link with the community	Look up to nurses as mentors and role models
Regard CHWs 'being there' as a source of comfort to them	Feel that nurses don't engage in teaching, they usually correct in a punitive manner
Regard CHWs as reliable and trustworthy	

In comparison with the initiation phase when the nurses were reluctant to accept referrals from CHWs, they now welcome them, as it is a sign to the nurses that the CHWs are working hard. As one nurse describes:

> "No. They are working well. They do their job. I don't have a problem with them. Because sometimes there will be some clients who come to us and tell us: "Nurse, I've been referred by Nompilo to come here." So that means they are doing their job. I don't have a complaint concerning them". *(RN6)*

This is a sign of the shift in thinking which occurs when nurses stop seeing CHWs as a threat, but rather as people who are there to help them. Unfortunately, there is evidence in this study that few nurses reach the stage of regarding CHWs as colleagues. This, however, may be more related to the lack of legal clarity on the role and function of CHWs that to a feeling of superiority. The following sister describes the vital connection which the CHWs provide between the nurse and patients:

> "I'm quite happy. I find them especially useful with my language and my follow up. It's comforting to know Oh, I didn't give this to that child. Oh yes, we can ask the health care workers. Or I'm worried about this child. I don't know if the mother understood how the treatment must be done. OK I can ask one of the health workers just to pop in there and see that everything is alright. You know that she's taking the medicine and that things are going well. I think it's a brilliant idea". *(RN7)*

"...fortunately we have the CHWs who can help us..."

Illustration 12: **A nurse in discussion with CHWs**

Knowing that there is somewhere for people to get help after the clinic is closed, provides some comfort to the nurse. They have begun to respect the CHW for the more important role which they provide in the community, whereas before they were considered useful only as an additional help in the clinic:

"But with the day hospital, it just ends at four and the patient goes back home. But then fortunately we have the CHWs who can help us to follow up the patients that we have sent home. If you're worried about something, we just give them the address and they go and check the patient at home". *(RN5)*

The nurses have also begun to value the knowledge which CHWs have, not only in terms of disease and illness, but also their knowledge of the referral system.

As one nurse describes:

> "I think here in Brown's Farm it's a good idea because we don't have twenty-four hours service. You see other patients they don't know where to go. Sometimes they help them...because with these people, maybe someone gets injured over the weekend, then they wait for this clinic on Monday. And when they come on Monday, you see that this wound is raw now. You can't suture this wound...and if the nompilo advise the patient to go to another clinic, nurses will suture the wound and refer the patient back to us". *(RN4)*

The importance of having CHWs available over weekends is further stressed by this nurse. She also acknowledges that nurses do not work outside the clinic performing home visits. They work together in the clinic, but the CHW performs the work 'outside':

"We worked together but not outside you see. Over the weekends, because we didn't open for the weekends. So if there's somebody maybe with burns and not second degree but maybe first degree, they treat the patient at home. And then on Monday they refer to us. And even NGOs, if they've got a problem, they come to us. So we are just working together". *(RN4)*

The following nurse recognises the role of CHWs in providing education in the community and the extensive knowledge which CHWs have to share. She does, however, say that if the clinic was open twenty four hours per day, then there would be no need for CHWs. This indicates the limited understanding of the CHW role: that they are assistants to the clinic, and that their priority is with physical wellbeing:

"Otherwise in Brown's Farm, I think it's OK. If there were twenty four hours I see no need. But in the case of education in the areas - I think there's a need because these nompilos they know a lot. Even more than we are as a sister. Because they know their work. Those who are serious they help them". *(RN4)*

Knowing the area and the people is also a link which the CHWs provide between the clinic and the community. As stated previously, none of the nurses working in the three clinics in this study actually lives in those areas. They say that they find it hard sometimes to locate patients as they do not know the system of house numbers or plots. This is especially important with TB patients who are required to take medication on a daily basis. The CHWs assist the nurses in finding patients, and can also provide information about any other problems in the home which may require attention. The following nurse describes the difficulty which she encounters when attempting to find patients:

"Yes, it's an informal settlement. The roads and these things are not established. You need to know somebody who knows their way around and so forth". *(RN7)*

Nurses also begin to rely on CHWs to inform the community about the clinic and the services which it offers. They see the CHWs as a way for them to 'penetrate' a community which they themselves do not know:

"In fact they should be helping us - telling the people about us. Because they know the people, they are staying with them in the community. So if you work hand in hand with them, it's very easy for you to penetrate the community. Making it easy for you to get somewhere". *(RN5)*

During this phase of greater understanding of the CHW role, nurses begin to consider them as the link between themselves and the community. With all the limitations of time, language, and not knowing the area, nurses realise the huge advantage to working with CHWs who can improve the effectiveness of the services which the nurses offer. The following nurse expresses her frustration at not being able to communicate with her patients:

> "Yes, I feel like: she's coming here and here's this idiot sitting who doesn't understand a word she says. You know it's not her fault, it's actually mine or my management's fault. I feel that she has the right to be able to speak in her own language and express herself. Now staffing and management problems are not hers. Now that frustrates me and it frustrates her" *(RN7)*

The problem of language places a huge barrier between nurses and their clients, and it is also a major reason why people choose not to use a health service. As one nurse who was the first Xhosa-speaking sister to be employed at one of the clinics explains:

> "Sister, we're happy it's a new sister who speaks Xhosa. That's why we are here. We haven't been coming to this clinic because we just didn't get what we wanted". So they stayed away but now they visit. There is somebody helping. Like family planning clients they come "Sister, I've got a problem. I have a PV discharge." "How long have you had this?" "Oh, it's about five months". "But you were here two months ago, why didn't you tell the sister?" "How could I because she wouldn't have understood what I was telling her". So she just preferred to stay away". *(RN2)*

The problems of language as described above cause patients to lose faith in the health services, because they are not understood or heard by the people they turn to for help. CHWs again play the role of accompanying people to the clinic and acting as translators when this is needed. This is more comforting for patients who often consider translators whom they do not know to be a threat to their confidentiality:

> "It does definitely make a difference because sometimes they want to tell you something in confidentiality. Then you must have an interpreter in between and they don't feel it's very confidential if you have someone else there. And I think if they have Xhosa-speaking people here it will go perfectly. Because then the client can tell you everything and you will understand everything, and you will know how to get back to that client". *(RN1)*

The ability to develop a relationship with a patient is also hampered by language barriers, and nurses who don't speak Xhosa often feel that they can never quite 'connect' with their patients:

> "Others haven't got the problem with the sisters because there are those who can communicate with them and they form a sort of friendship. I can say a friendship where they're happy. But there are those who really can't, because they can't speak the language. It's frustrating for them". *(RN2)*

The involvement of community members in the planning and evaluation of health services is also not possible if health providers can't speak Xhosa. The principle of community involvement in health is fundamental to the primary health care approach, however, in many communities this is simply not attempted because of language barriers. As one nurse describes:

> "The one thing I do find a hassle is the language. Obviously I've got no Xhosa. But if I was in a coloured or even white clinic, it would be easy for me to communicate with people, telling them how you would like the service to be run. Ask for their co-operation and I suppose things would be smoother. But that is a problem that I have". *(RN7)*

There are thus many barriers to nurses working effectively in the community setting. This provides an opportune environment for CHWs to act as the link between nurses and the communities in which they work. The locus of practice of community nurses is predominantly within the walls of the clinic, yet it is the people on the outside of this ominous-looking building who require information in order to make choices regarding their health. This is where the CHW plays a vital role. As one nurse described:

> "I see the health workers as your link between you and that community out there". *(RN7)*

This nurse's use of the words 'out there' highlights the distance between the community and the health service within it. It is regarded as a separate world within a community, which is often so foreign and unknown by the community that, as described in phase two, they simply walk past it.

The nurse that I interviewed who works for an NGO which runs a CHW project, sheds some light on the different roles of non-governmental health services and formal health services:

> "And the clinics themselves...you know because our CHWs are doing home visits which I think that the nurses in the clinics cannot do because of the influx in the clinics. There are so many people that go to the clinic so they do not have time to do door-to-door which we as NGO can do". *(RN3)*

This nurse acknowledges the limitations which prevent nurses from being out in the community. She emphasises the unique opportunity which this provides for CHWs to bridge the gap. She continues to discuss health education and the inappropriate reliance of the government on television and radio as the medium for delivering health messages. Again, she encourages the use of CHWs as perfectly situated vehicles for health information:

> "For instance the HIV/AIDS, who has time to go and do health education in the communities? Who has time to go to the rural and squatter areas to talk about...because if you are relying on radios and TVs how many people have time to look at TV and listen to radios? But if we do use the availability of the CHWs... if the government could embark on using the CHWs to do the campaigns of the HIV, I'll say they recognise them". *(RN3)*

There is a concept which this nurse talks about which incorporates her understanding of CHWs and the different levels of involvement between nurses and CHWs:

> "We do not know that at the end of the day the government is trying by all means and we *(CHW project)* need to be the eye of the government". *(RN3)*

This nurse stresses the importance of working together, drawing on others' skills rather than undermining them. As a nurse rather than a CHW she understands the stresses and limitations which prevent nurses from practising at their optimum potential. She is not critical of them. Rather she motivates them to accept what they can't do and to turn to people who can fill that gap:

> "So we are dealing with the kinds of things that will be very difficult for the government to do. Because they deal with the cases that are reported. For them to actually go and check the problem in the community...I don't think they have time to do that. So that is why it is very important to network and work together". *(RN3)*

In terms of the role of nurses in educating and mentoring CHWs, this is seen by CHWs as an important part of their interaction. They look up to nurses as the professionals who have more knowledge, and are eager to learn from them. Unfortunately, most nurses do not engage in teaching CHWs, and in the experience of CHWs in this study, when teaching does occur, it is usually done in a punitive, reprimanding manner when the CHWs have made an error. CHWs feel that nurses have very high expectations of them, and that they should be faultless. When they do make a mistake CHWs expect the nurses to correct them in a constructive manner and to assist them with their ongoing education. As one CHW described:

> "As CHWs, we expect more from nurses in the clinics because they are the professionals. I mean, they are the people who are destructive when they criticize us, or when they confront us. I mean, a professional confrontation from them as the people who are professionals. I mean, it's bad when you see your paper teared down and thrown away. And when they criticize you, they criticize you destructively. They can't motivate you. I think that's the main problem that we experience from the clinic staff". *(FG1)*

Unfortunately, as described above, the 'mentoring' which is received is done in a critical and destructive manner. This gives CHWs a very poor impression of a profession that they had previously idolised. The following account highlights the high expectations which nurses place on CHWs:

> "But the only thing that I don't like is that the people don't think that I can be a person who can do a mistake. Even the people who are professionals, they don't expect mistake to me. Whereas I make mistakes. And I have to help the mistakes. I expect a person if ever I make a mistake in front of a person who is a professional, I expect them to come and correct me". *(CHW7)*

Unless it is a glaring error which requires immediate correction, nurses often wait for CHWs to approach them if they require information about something. The following CHW shares her experience of having to ask the nurses to teach her. It seems that they do not volunteer information:

> "Unless you ask. It's a matter of asking if you need to know what was wrong with the patient. And that's when they tell you. It's not just for them to tell you what was wrong with the client" *(FG1)*

The following nurse shares the expectation of nurses that CHWs will ask for help when they need it, and they seem quite willing to assist in this manner:

> "It was good because they are there when you see them. The problems they can't manage they ask you and you have to explain everything to them". *(RN2)*

This nurse also comments on the availability of CHWs. The following nurse highlights the dramatic progression which can be seen in the mindset of nurses when they begin to understand the true role of CHWs and to see them as a help rather than a threat:

> "Like one of my colleagues asked: "Why are you giving Myrin* and why is it changed to Rifinah*?" So I said: No, I don't have a problem with that because they have been trained. And if they don't know, we're going to tell them as we move along". They are going to grow and we are going to grow". *(RN7)* **Names of medications for the treatment of Tuberculosis*

This is the first example of a nurse defending a CHW to another nurse. It signifies that a definite change in mindset has occurred. The issue of CHW education which constituted the biggest barrier to establishing relations between them, is now accepted by a nurse. She verbalises what CHWs strive to achieve in their relationship with nurses, that of mutual nurturing and growth. This is ultimately what leads to a dynamic, cohesive district health team.

There has also been a change in the practice of CHWs since both of these projects were established. They have learnt from the nurses and problems have been resolved along the way:

> "Because in 1994, they started this project so they have in that time, those mistakes. Like if they saw a big wound, they dress the wound not to refer and said the patient must come to me, not to go to hospital. And if that patient now has complications - come very late - with a raw big wound ...but we've corrected those things. No problems". *(RN4)*

Clinical judgements as described above come with experience, and nurses have the experience to share with CHWs in order to improve their competency and decision-making skills. The following nurse captures the stage which most nurses reach during this phase where they value the work of CHWs and see them as a help rather than a threat:

> "They are here to help us. We can always rectify them along the way. But they are definitely a big help to us". *(RN1)*

This stage is characterised by greater understanding and respect between nurses and CHWs. Nurses realise the advantages of working with CHWs, and the important role which they play in the community. CHWs are also less exploited during this phase, as the nurses understand their role as being the link between the health service and the community, which requires them to be available in the community and not performing tasks in the clinic.

The nurses, none of whom live in the community where they work, have come to value the presence of CHWs in the community after hours and on weekends when they are not there. This provides nurses with a sense of comfort and reassurance that there are people who have the knowledge to deal with emergencies when they arise.

Having worked with CHWs for approximately a year, the nurses have also come into contact with the NGO sector as the initiators of CHW projects. They begin to grasp the importance of networking and the distinctly different roles of formal and non-governmental health care providers.

As they become more accepted by nurses, CHWs begin to look up to them as mentors and teachers. Nurses, however, do not engage in teaching unless the CHWs have made a visible error and need correcting.

The three stages described above track the complex changes which occur in the relationship between CHWs and nurses. Even if the relationship often remains an uneasy co-operation, major shifts are seen in the mindset of nurses as they begin to understand the role of CHWs as the link between the community and the clinic.

5.3 CONSTRUCTIVE AND DESTRUCTIVE INFLUENCES ON THE RELATIONSHIP

From the process described in the previous section it can be clearly seen that certain experiences, processes and organisational arrangements contribute in either a constructive or destructive manner to the development of a relationship between nurses and CHWs. It was evident in this study, and illustrated by the table below, that the destructive influences were described far more often than the constructive. As a result, it is predominantly these negative aspects which are described here. One can assume though, that each destructive factor should have an opposite constructive factor, and that altering each of the destructive factors should improve the relationship. However, only those constructive influences which were evident in the study are discussed.

DESTRUCTIVE INFLUENCES	CONSTRUCTIVE INFLUENCES
Narrow orientation of nurses	Sitting down to talk about issues
CHW training is not trusted	Understanding the role of CHWs
Nurses are often 'being moved'	
The stress of being short-staffed	
The fear people have of nurses	
Different styles of relating to people	

5.3.1 Destructive Influences

As described in the literature review, nursing education in South Africa has focussed on preparing nurses for practice in tertiary hospitals. There is less emphasis on community nursing and the skills required for working with people in this setting. Working in primary level facilities places high demands and expectations on nurses who are relatively isolated and have greater responsibilities compared with nurses working in a tertiary hospital setting.

i) Narrow orientation of nurses

In this study, there were nurses who came to work in the clinics and encountered a type of health worker they had never heard of before. Even if these nurses had chosen to work in the community, they were familiar with and mostly trained for hospital-based work. In the hospital setting the nurse is often the one in control, and therefore holds the power in most relationships with patients. Much of the data in this study showed the nurse 'in control', wielding her power in

the clinic setting, especially with patients and CHWs. The nurse below, with a broader orientation and perspective, describes it like this:

> "So I think some nurses have the old bureaucratic way of training. They think they are the best. They are the only ones. They cannot work with other people who are not educated. I mean, that alone is not acceptable. Because you've got to be flexible when it comes to communities. Because even a traditional healer, when they come to your clinic, you must accept them, so that you are able to get the things that they use. You don't say: "Go away. I don't accept you". Who are you to say that to the people? It's a kind of relationship that you develop with the people". *(RN3)*

CHWs are aware of the significant change in attitude which is required for nurses to begin to acknowledge them. They know that before they started working, most nurses would never have encountered a CHW before. As one CHW describes:

> "Because when our nurses were trained before there were no CHWs. It was only clinic and nurses. Now it's not easy to change". *(CHW4)*

A lack of understanding of the primary health care approach as a philosophy and not a package of services, is also something which hampers nurses from being able to embrace the concept of CHWs. As the nurse working for an NGO describes:

> "You know as a professional nurse working in the community I get reports from CHWs that they get negative attitudes. When we refer people they don't accept their letters. I think it's a question of understanding the problems of the community. It's a question of understanding the approaches in primary health care. Once you understand primary health care you will accept any letter which comes to you. Because it's your duty as a professional nurse to investigate. Not to undermine the letter and check the English written in the letter and say: "Who are you to tell me...who are you to refer a patient to me?" *(RN3)*

The situation described above is a result of nurses being unaware of the role of CHWs. This nurse believes that information about CHWs should be included in all nursing education courses in order for nurses to understand the role of CHWs and to prevent them from regarding CHWs as a threat:

"And maybe the other thing we should embark on, is a question of the information to the nurses. They must know that there is someone who is working in that area. Who she is. What she is doing in that community. So that when the letter comes to you, you'll know that there is a community health worker in such and such a place". *(RN3)*

ii) CHW training is not trusted

As discussed earlier, the legislation pertaining to CHWs is unclear and they have no official position within the health care team. All CHWs in South Africa complete the same training course. However, this is not accredited with the National Qualifications Framework and therefore has no recognised status as a qualification.

Analysis revealed that much confusion exists over the role of CHWs and this certainly impedes their relationship with nurses. Nurses often feel that it is unfair that they had to complete four years of training and CHWs arrive with three months of training and expect to be accepted by them. If this qualification were accredited then it would help to clarify the role of CHWs and their precise functions and 'scope of practice'.

iii) Nurses are often 'being moved'

It was evident in this study that nurses working in community clinics are frequently moved according to needs in other clinics. This is often done without consultation with nurses, and they may also be placed in a position for which they are not adequately trained or experienced, such as clinic manager. This makes developing a team spirit amongst clinic staff extremely difficult. My observations were that nurses are often assigned specific tasks for the day, and little team work is involved. It is not surprising therefore, that welcoming another group of people into their space is difficult for nurses. They struggle to form a bond as a group of nurses even without the addition of outsiders.

'Being moved' has become an expected occurrence for many nurses in this study. They know that they cannot get too comfortable in any work environment because at some stage they will be sent to work somewhere else. This practice is not limited to the hospital environment and for the clinic nurse involves far more than having to move to another ward. It means moving to a completely new area with its own unique challenges to confront. One nurse explained to me how being moved was part of how she understood her role as a nurse, and something which one needs to adapt to and accept:

"I think every nurse, from the day that you start nursing, this is a reality. You get moved from ward to ward; you learn to adapt fast. It's not like you can say: This is my office and here I'm going to be forever". You move around. OK ,that isn't even relevant because we are always moving around...and this is what nursing is like; we've always been used in that way. We could never claim our rights...you as a nurse are aware of the fact that you must move, and you must move where the need is. This is it you know". *(RN7)*

This nurse, although being able cognitively to rationalise the reasons why nurses are moved, also has a strong feeling of being taken for granted and abused. She speaks of having no rights, and even if she sounds resigned to this fact, the statement indicates the disturbing manner in which these nurses are being exploited.

This nurse was recently moved to a clinic to take on the role of clinic manager. She was not informed prior to the move that she was expected to take on the managerial role. Despite having no experience in management, and training predominantly as an adult clinical nurse practitioner, she was moved to a local authority clinic which offers primarily child health services. She describes her first impressions of the new work environment:

"And I just found myself thrust in here and having to be the manager. And that part I don't like ...and now you're forced to do this". *(RN7)*

There is an overwhelming sense of powerlessness around being moved. The decision is not questioned and the nurse has to put her own feelings aside in order to do what is demanded of her. The indoctrinated nature in which nurses perceive being moved, has led them to believe that it is right and acceptable. As one nurse explained:

"Nobody stays in the clinic for a long time. We are being changed. When the time comes I'll be changed to another clinic, and I feel that is right". *(RN6)*

The following nurse admits that she does not enjoy being moved. She describes how she disregards her own feelings, and concentrates on delivering the service which is expected of her:

"So when you get told that you must move it's not always nice, but I think I've been moved around enough to get used to it. You just have to go. You have to deliver a service there to the best of your ability. That is it". *(RN7)*

However, the frequent movement of staff has a profound effect on interpersonal dynamics and on the cohesiveness of the clinic as an organisation. Staff report finding it difficult to create any team spirit with the knowledge that nobody stays for very long. The constant changing of staff creates despondency, for just as they are beginning to work well together they are split up again. One nurse describes a situation when a nurse was moved and another did not like the environment without her colleague and decided to resign:

> "...very stressful, and I think they made us despondent. Because we are working like a team...and then one of the sisters had to be moved to Hout Bay and it made us upset because we've been working as a team. But they broke that spirit taking one away. And then the other one couldn't handle the pressure and she resigned immediately. She had to go at the end of the month but she went in the middle of the month. And that made me very despondent because we were very close". *(RN1)*

One of the nurses who was employed to replace those mentioned above, was alarmed at the tense atmosphere in the clinic after the two sisters left. She arrived at this clinic at a very difficult time when the only remaining nurse was feeling abandoned and angry at the 'system' which broke the team spirit which was previously present. Her perceptions of this are that:

> "The staff here have been traumatised almost because of poor ...or existing problems". *(RN7)*

iv) The stress of being short-staffed

Being short of staff was a frequent complaint amongst the nurses that I interviewed. They felt that they were pushed beyond their physical capabilities, but more importantly, they were forced to take on the role of other health professionals, most commonly pharmacists. None of these three clinics had pharmacists, and frequently a sister was allocated to work in the pharmacy for the whole day. They report that this is a complete waste of a registered nurse's clinical skills, and places a huge burden on those who are left to manage the patients. As one nurse described:

> "It's too much for us in this clinic because we are short staffed, and there are many patients coming to us every day. We've got no pharmacists, we are also pharmacists. And the community, it's too much". *(RN4)*

Many nurses spoke about the high mobility of patients attending clinics in informal settlements and that the patient numbers are increasing every month. However, there is not a corresponding increase in staff, resulting in staff feeling unable to cope:

> "...staff problem. We are too little to cope with the people in this area. We tried our best and we are working very hard". *(RN1)*

The nurses expressed not being able to provide the type of care which they would like to, because of the large numbers of patients and staff shortages:

> "But sometimes you really can't do much, even if you want to do more because of the long queue waiting for you. So if someone comes then you really feel that you're not giving her what she wanted. She wanted something more, like talking. But where is the time? There is such a long queue waiting for you". *(FG2)*

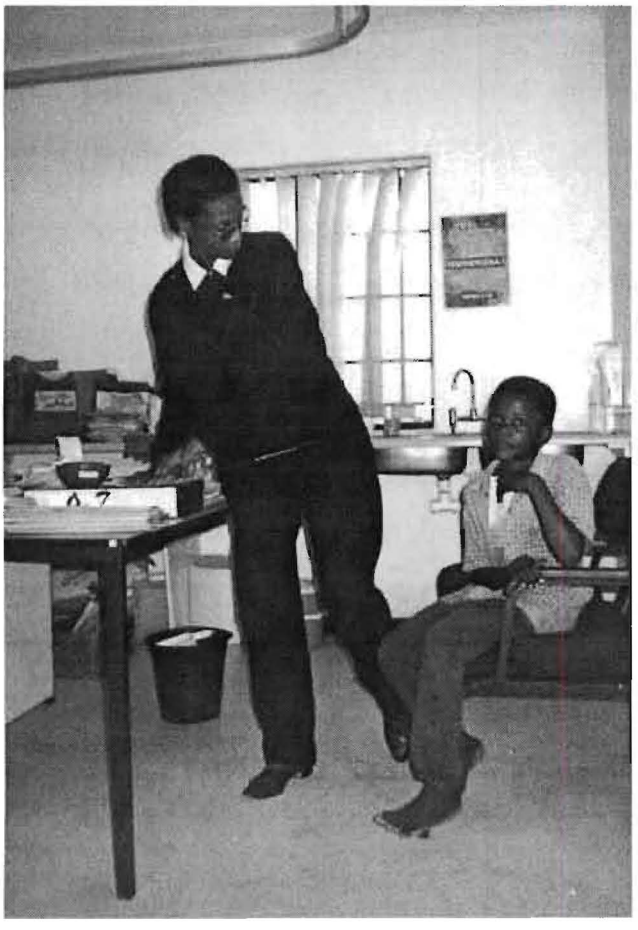


Illustration 13: **A Nurse recording TB treatment given to a young boy**

It is recognised that some patients don't come to the clinic for treatment or medication but rather for a listening ear. The nurses find it difficult to provide this support within an extremely stressful environment:

> "And the patients, they sort of develop trust when there's a nurse working with them. So even that would make them feel better. Because sometimes they come and it's not a bottle of cough mixture that they want - it's you". *(FG2)*

Some nurses have just become accustomed to working with too few staff and have accepted that things will not change. It has become an expected part of clinic work:

"There is a shortage of staff, but that is a usual thing - nothing one can do about it in most cases, most of the clinics have a shortage of staff". *(RN6)*

The pressure which results from being short-staffed sometimes leads to passive forms of resistance among nurses. They choose to stay away from work in the hope that the management will take notice and send more staff. They do not however, choose to confront management and put their grievances to them in a constructive manner. As one nurse who experienced colleagues' absenteeism described:

> "There were days when I was here all by myself. When you were coming to work you didn't know what to expect. They come on duty or they won't come on duty. So you just sort of get used to that. I'm going to work and I'll accept whatever I find". *(RN2)*

The uncertain and unpredictable work environment as described above characterises all three of the clinics in this study, and had resulted in tremendous physical and emotional strain for nurses. The following three nurses describe how the stressful environment has affected them:

> "We don't have lunch at times. No tea time sometimes. It's just rushing, especially if you get emergencies. Because you must look to those emergencies. Just leave everything and look to those emergencies. Otherwise, we try our best but man we are tired". *(RN4)*

> "And I think we're burning ourselves out. You can see it in everybody, they are really burnt out. Even the cleaners we are using them as interpreters". *(RN1)*

> "That is why we are suffering. We are tired always". *(RN4)*

Working with a high level of stress can also result in nurses taking out their frustration on patients. This leads to nurses being feared, and consequently not trusted by the community. As one nurse shared:

> "And you know when you are stressed you say the wrong thing in front of the patient. It irritates you". *(RN1)*

These findings provide insights into how community nurses feel about their work. It is clear these nurses face substantial challenges on a daily basis which have a direct impact on their ability to deliver quality patient care, as well as their relationship with CHWs.

v) The fear people have of nurses

It became evident from analysis of data that many community members have had bad experiences in clinics, and this leads them to fear going there. The CHWs often have to accompany individuals to the clinic in order for them to feel safe and able to share their problems with the nurses.

The CHWs recognise the difficulty which their clients experience when going to the clinic; the frustration when they are not heard and understood. This has lead to many people in these communities choosing not to go to the clinic. However, there are still others who are unaware of the clinic. The following CHW highlights the lack of knowledge which exists around available health services. Here mention is made of people being scared:

> "They *(CHWs)* are not scared to go from house to house. There are people in their homes who are sick, who didn't have a chance to go to hospital or who hadn't got the knowledge of hospitals or nurses. And some are scared". *(CHW8)*

Another CHW confirms these sentiments and believes that people choose to consult the CHWs before going to the clinic because they are scared and feel safer if the CHWs as their advocates accompany them to this 'fearful' place:

> "Ja, because there is that fear of the nurses. So they prefer to come and say the problem to the CHWs first. Then it can be the CHW who is taking it inside the clinic. Then they know that they are going to be helped if they go through that channel. And they know that we take time to do it. We don't just say "OK, go to the clinic". We sit down and we ask them questions. And we give the information to the patient. That's why they say that they will wait for us. They won't go there. They know the only channel is the CHW. Otherwise they won't just go to the clinic and tell the sister that they've got this problem. Because if she wants to, she can just ignore that". *(FG1)*

Before starting work as CHWs the only interaction which CHWs have had with nurses has been as patients attending the clinic. Many CHWs speak of having negative experiences of the nurses. They seem powerful and controlling, and this engenders fear in people. As one CHW describes:

> "So for the first time it was difficult because I didn't know anything about the clinic - even me from the community. And then I was scared to come inside if I was a defaulter. But now we tell the people about the defaulters and it's OK for the first time". *(CHW6)*

During interactions with nurses, especially when a project is first established, CHWs regard themselves as being inferior. This is largely because of their experiences of nurses as being powerful. They are reluctant to initiate discussion with them out of fear and insecurities related to their own precarious sense of belonging within the health care team. The following CHW describes a client's feelings about nurses:

> "Ja, they say they were being shouted at the clinic. And they didn't know who to speak to. So that is why if they defaulted then they know that they're going to be shouted or not to be cared for. So that is why they didn't go to the clinic". *(CHW8)*

It is very sad to hear of patients feeling uncared for as caring is the basis of nursing practice. These images of nurses shouting at patients hampers CHWs from approaching them in order to share their role and functions. This leads to confusion and misunderstanding - certainly not a good foundation on which to build relationships.

vi) Different styles of relating to people

It became evident that there was a difference in work philosophy between CHWs and nurses. CHWs help people because they belong to the community and have a desire to do so, whereas nurses assist patients out of an ethical responsibility related to belonging to a profession.

The different way in which CHWs and nurses interact with patients also impedes the process of establishing a relationship between these two groups. A person's style of interacting with patients is largely moulded by their training, personality and personal belief system. It was noted during time spent in the clinics and through participant observation that the nurse-patient relationship is a distinctly hierarchical one, where the nurse holds the power and the patient is the passive recipient of health care.

The philosophy inherent in the training of CHWs is that of partnership and sharing of ideas, with control and decision-making in the hands of the client rather than the CHW. An openness to learning from clients is also displayed by CHWs. They are not 'educating the uneducated' but rather sharing ideas and entering into discussion with their clients:

> "We also need advice from the people. That's why when we are doing workshops don't be shy to talk. Maybe people say that we know everything. No, we also want to learn from you". *(CHW2)*

For CHWs, workshops are an interactive process. They try and make learning fun by including music and drama, thereby creating a comfortable environment conducive to participation:

"When we do workshops we share our ideas and you can give us your ideas". *(CHW2)*

Another CHW also emphasises communication as a pivotal component of their role:

"I like my work because first of all, I have communication with the people". *(CHW 3)*

The nurses in this study spoke about interactions with patients in a radically different manner to the CHWs. For these nurses, patients are people who need to be 'educated' and 'disciplined'. It is described as a one-sided relationship where the nurse gives and the patient receives. The following two quotes are examples of the controlling attitude which these nurses have towards patients:

Illustration 14: **A CHW with a client**

"It's just that people here haven't been told and disciplined. That when it's time to attend to them we'll attend to them". *(RN2)*

"They need to be educated and it will take a very long time". *(RN1)*

The following CHW describes her experiences of nurses' interaction with patients and how this has resulted in patients avoiding the clinic, and thus not getting the treatment which they require:

"Frequently, when I worked closely with the nurses, I've noticed that they don't have a good approach. So that is why the people are scared of them. Especially in the case of family planning, you'll find that most of the family planning defaulters are scared of the nurses in the clinics. They say that if they default and they go to the clinic, the nurses will shout at the patient. And then the

person who has defaulted will decide not to attend the clinic again. And since we've started with our project and taking them, they are very satisfied with that. And yet, we are doing all to take them and go with them to the clinic staff. And we talk to the clinic staff without them having to make contact with them themselves". *(FG1)*

For the CHW, the home is an important environment for being able to find out 'what is really happening' in the family. Within the clinic setting I observed people sharing specific physical problems. They were not encouraged or given the space to share about other social or emotional issues affecting them. The advantage which CHWs have, is that they have more time than nurses to spend with patients. They are gentle, and being from the same community as their clients, they are known and trusted. The home is thus a vital space for education as the clients don't feel threatened in their own environment and are comfortable to share their problems:

"So as a CHW you come. You come and you knock and you talk nicely. And they cough out everything. And if they are maybe staying alone and they can't walk, you ask the neighbours to help you carry them". *(CHW2)*

The above quote illuminates the immense respect which CHWs show their clients. They knock on the door and wait to be invited into the house, they talk in a gentle manner and this enables clients to trust and share with the CHWs. Being non-judgemental is also vital to the respect and trust which is afforded CHWs. They do not want to be seen by the community as policemen who are coming to criticise them. They want to be seen as neighbours who are there to listen. One CHW describes this very aptly:

"So we are not high, we are down to get the problems of the people. Because we are here to help them". *(CHW2)*

This emphasises the non-hierarchical nature of the CHW position. Compared with nursing, where nurses are subdivided according to qualification and experience, the CHW is still regarded as a CHW even if he/she has been working for ten years. Thus the CHW is not feared by the community but rather respected as a friend:

"Even the HIV patient. You as a CHW they are coughing out everything because we don't say why is your house dirty, why are you dirty. You are just coming as a neighbour, just talking." *(CHW2)*

Just as the CHW is motivated by a desire to help their community, so are nurses bound by a responsibility to treat clients. There is however, an ethical responsibility, as they are part of the profession of nursing. There is a distinct difference in the responses of nurses and CHWs towards patients. CHWs welcome having the time to spend with patients and enjoy this interaction. Nurses, due to the large numbers of patients which they must treat each day, and the stress of clinic work, often have negative feelings toward patients as they see them as more work. After the appointment of a new sister who is trained as an adult clinical nurse practitioner, this clinic began seeing adult patients as well as children, which has further increased the patient load:

> "And now all the adults are flocking in - and you can't say no. If a person is standing here you must see that client". Everybody comes in and you can't say no because she's trained in that field". *(RN1)*

The tone of the above statements suggest that nurses help patients because they are obliged to. This is a sad reflection on nursing which is conceptualised as a caring profession. It seems that the highly stressful environments in which these nurses work has resulted in a change in their attitude towards patients and their own feelings about their work. As has become evident in this study, nurses report getting angry with patients when they are stressed, which they see as a direct result of the enormous pressure and responsibility placed on them. The following nurse describes feeling trapped in her work. She has to treat patients because there is no other option:

> "But we try to manage our patients because you can't do otherwise. We must work and help our patients because they need curative and preventative measures". *(RN4)*

The following nurse expresses the absolute frustration which many nurses experience. They are so stressed that they just want to chase the patients away. However, their ethical responsibility prevents them from doing this and they continue in the same destructive environment with no glimmer of change:

> "And you can't chase them away. You have to do them". *(RN1)*

Witnessing negative attitudes towards patients and encountering dissatisfaction from community members towards nurses, makes it difficult for CHWs to feel positive about working with them. They simply cannot condone the approach of nurses and find it extremely difficult at times to be seen as 'part of them'.

A complicating factor in the development of a relationship between nurses and CHWs is that clients often cause splitting between these two groups. If a client doesn't receive satisfactory care from the nurses, they often turn to the CHWs as their advocates. This creates much anger amongst the nurses who feel that CHWs should support them. One nurse describes a situation where a patient complained about the nurses to the CHWs:

> "There is one thing though that I find quite disturbing: a colleague saw a child and treated the child. The parents go off to the health care workers and say that yes, that is what the sister did. She wasn't happy. She told the health care worker that she was unhappy about the treatment, and the sister didn't treat the child properly. And I picked up from the health care worker: You people saw this child and look how this child looks" - or things like that". *(RN7)*

This situation presents some difficulty for the CHWs. Part of their role is to be advocates for the community, however they are also trying to develop a relationship with the nurses and anything which appears like criticism of them tends to destroy this relationship.

5.3.2 Constructive Influences

i) Sitting down to talk about issues

As discussed in the previous section, the lack of knowledge about the CHW role emerged as the biggest impediment to establishing a relationship between nurses and CHWs. In both sites the solution to this problem was to sit down and talk. The length of time which it took for this meeting to occur varied between sites but it was generally a few months after the project had been established and was often pre-empted by a major disagreement which required crisis management, rather than a mutually agreed upon planned meeting. The initiator of this meeting was usually the CHWs who would bring in their co-ordinators to act as mediators to manage the conflict which had inevitably occurred.

In fact, the process of setting up meetings was often initially damaging to the relationship. The CHWs experienced many failed attempts to meet with the nurses during the initiation phase of the project, and felt that the nurses were avoiding attempts to discuss issues. As one CHW reports:

> "Ja, there are still more things which need to be resolved. Because most of the time we set up a meeting but they didn't turn up. So there are a lot of things which need to be solved". *(CHW8)*

Another CHW experienced the same problem:

> "If you want to meet to discuss something the people are running". *(CHW6)*

However, after an initial meeting where both parties were able to express their feelings, remarkable changes in the patterns of relating could be observed. Both of these groups realised the value of listening to one another, and there is now a monthly meeting in both areas where nurses and CHWs discuss problems and work together to plan initiatives such as workshops and immunisation campaigns. This has led to a change in behaviour, as when issues arise now, both parties feel able to sit down and talk, instead of harbouring ill feelings towards one another. As one nurse describes:

> "But if we've got a problem and we are not satisfied, we just sit down with them: "OK, maybe this case. We're not supposed to do this and this. You must try and do this and this..." Even them, if they've got a problem, they come to us". *(RN4)*

A commitment to working together is also important to foster, as when there is even one nurse in the clinic who supports CHWs, her example will influence the behaviour of others:

> "The clinic opened in 1994, and when I got here in 1997, they've had some experiences where they have quarreled with them. But ever since I was here, I haven't had any problems. And that's another thing that I'm really trying hard - bringing them together. But I think that I have succeeded in that because there are really no problems". *(RN5)*

The nurse working for the NGO also expresses her feelings about an observed change in the relations between nurses and CHWs after their roles and functions were clarified:

> "I think most clinics now there is something going on. They are changing a bit. But I think it was the understanding of CHWs to some nurses". *(RN3)*

The following nurse reflects on the changes which have occurred since one of the CHW projects was established:

> "There is quite a good relationship between most of us and them. What we actually had we worked away and we started fresh now. And we want this thing to work in.... This is actually

what is going to make it one hundred percent. Because we want, I think we are the only clinic that wants this to work. We want the health workers to be part of us. And we must be part of them". *(RN1)*

They have progressed to a stage of valuing the relationship and respecting each other. In this site there is also a physical closeness, as the CHWs were given their own office after building extensions were made to the clinic. The CHWs moved into this office eighteen months after the project was initiated. This is a unique situation which does not occur in any other CHW project in the Western Cape. The relinquishing of a room signified a commitment on the part of the South Peninsula Municipality and the nurses at Nomzamo clinic to work together with the CHWs. The use of the words 'part of' indicates both an emotional and physical connection, as the health workers are both part of them in the sense of working together towards common goals, and because they also belong in the clinic in the physical sense of having an office there. The feelings of the CHWs towards the process of sitting down and talking with the nurses, is one of relief. It signifies for them that they have survived the stage of being undermined, and for the first time are understood and heard. The following two CHWs explain this change:

"In the beginning they treated us a little bit with harassment. But now they know about nompilos. As I've said they didn't know about nompilos firstly. That's why they treat us badly". *(CHW3)*

"They undermined us before but now they understand about us because we are helping clinics, we are referring to clinics". *(CHW4)*

The following account describes the struggle which the CHWs in one project had after they had received training as TB supporters. Initially the nurses were reluctant to trust them and refused to let them supervise patients. After meeting together with the trainers from the TB Care Association, the nurses began to realise the substantial knowledge which the CHWs had, and were able to relinquish some control and responsibility to them:

"When we started this TB project before, they took it away from us, because they were busy undermining us. But now, since last year, we are together in the meetings and the workshops. We are together in the courses now. They know now that we can do that job. They've sent too many clients to us, and the defaulters too. And they tell the people about us now. They have our house numbers now. We are working fine now as we attend workshops, courses and meetings". *(FG1)*

Sitting down and explaining their role and how it is complementary to the nurses' work seems to dispel the nurses' fears that CHWs are there to take their work away from them:

> "Then we formed the groups with them, we started to talk to them. And we tell them: "That is our work and it's also related to your work with this and this and that". Then they accepted us". *(CHW3)*

The clarification of roles is the vital first step towards understanding between these two groups of people. This process is, however, complicated by the fact that the legislation pertaining to CHWs is contradicting and unclear. If a CHW project is initiated through a process of involving the nurses and acknowledging their fears, then the painful experiences of being undermined and feeling threatened can hopefully be avoided or, more importantly, confronted as they occur.

ii) Understanding the role of CHWs

A nurse with previous encounters with CHWs is a definite asset when establishing a CHW project. Just to have one person who knows who they are and what their role is makes initial contact with the clinic much less daunting. One nurse who began working at one of the clinics a year after the CHW project was established, was quite shocked to find the 'distance' which was present between the nurses and CHWs. This nurse had worked previously for an NGO and was involved in training CHWs. She therefore had an intimate understanding of the role of CHWs:

> " I was worried when I came here to find that the CHWs are here and the clinic is here. You know I just could not understand it. Because I know CHWs as part of the health system. So they should be part of the clinic. At night we are not here, weekends we are not here. They are the people who know the community and who are in the community most of the time so they should be part of us". *(RN2)*

It is clear that this nurse has captured the essence of the link which should exist between nurses and CHWs. They complement each other, as each group has its own unique role and function, but they are working towards the same goal - that of uplifting the standard of health in a community. The following nurse had also worked with CHWs before and had an understanding of their role:

> "Because even in Site C where I was working, they are working with us in the clinic, and then they would go out during the day for visits and all those". *(RN8)*

One sister who started at one of the clinics during the time that I was conducting this study, who had previously worked for another CHW project, was very surprised to find that the sister in charge of the clinic knew very little about the CHWs:

> "I wanted to hear her views because I couldn't understand. And she seemed not to know anything, which really surprised me as the sister in charge of the clinic". *(RN2)*

One of the CHWs had been involved with a clinic on a voluntary basis prior to becoming a CHW. This really helped her to establish relationships with the nurses, as she was known and respected by them. This caused some jealousy amongst her colleagues who felt that the nurses favoured this particular CHW. It was this CHW who was approached by the matron of the clinic and offered a job as an administrative clerk. This woman's potential and skills had been noticed by the nurses and they wanted the benefit of these for themselves. This CHW explains her previous involvement with the clinic:

> "I liked it because before I'd been working with the clinic, before I was a CHW, Sister X, who is now working in Ocean View gave me an opportunity of looking after an AIDS patient. It was my neighbour and that was close to me as a relative. So I've been looking after that lady until she died". *(CHW5)*

It is evident that having previous experience with CHWs has a definite impact on the attitudes of nurses towards them. This, however, is still directly related to understanding their role and can be facilitated on a broader level through the reorientation of health personnel.

Chapter 6
DISCUSSION OF FINDINGS

This study has explored the working relationship between CHWs and nurses. It was found to involve complex interpersonal dynamics related primarily to role identities. It was evident there is a particular process which is set in motion when a CHW project is initiated in a community. In the first stage this is characterised by confusion on both sides. CHWs are attempting to understand their identity within the health system, and nurses are struggling to understand the CHW role and functions. This progresses to a phase of exploitation and undermining, as the usefulness of CHWs is exploited by nurses who begin to use them to perform nursing tasks within the clinic. CHWs who have little credibility and belonging within the health system accept the opportunity to work within the clinic as they aspire to have the status of nurses. The final phase involves nurses realising that CHWs provide a link between themselves and the community, and the presence of CHWs in the community after hours is a source of comfort to the nurses. CHWs look up to nurses as mentors and begin to value the significance of their own role within their communities.

What follows is a discussion of major findings and discourse around issues of major significance to this study. These include: challenges facing CHWs; challenges facing community nurses; the clinic as an organisation and social system; informal settlements and the concept of community; and health seeking behaviour and the concept of *ubuntu*.

6.1 CHALLENGES FACING CHW PROJECTS

As described in the results of this study, the biggest threat to the survival of CHW projects is their lack of recognition from the National Department of Health. The following nurse who works for an NGO describes the need for greater understanding of the CHW role:

> "Once they understand the role of the CHW, it will be very easy for the legislator to formulate a policy and make sure that some functions are given to the CHWs, and get paid through those functions that are going to be given to the CHWs. At the moment, the government is still struggling to actually get what the CHWs are doing. That is the feeling of the CHWs - that they are not recognised by the government". *(RN3)*

According to Ramirez-Valles (1998) CHW projects are implemented where there is a 'need', such as in situations where there is poverty, lack of attention to women's health, poor access to health services and where people are oppressed or overlooked. The initiation of these projects has occurred at the same time as some major shifts in health care and in the socio-political environment in many Third World countries. Fundamentally, it is this enormous gap between the pressure of ideas and expectations on the one side, and the realities of development and socio-political situations on the other, which has led to the growth of health projects involving CHWs. According to Vaughan (1980), in order for the crucial role that CHWs play to become accepted, we need to acknowledge that the end of poverty and underdevelopment in the Third World is not 'around the corner'.

CHWs are seen as a bridge between the community and the health system. However, according to Skeet (1984) the concept of CHWs is deceptively simple, and vulnerability as well as strengths can be found in this bridging function itself. The efficiency, effectiveness and safe practice of the CHW depends upon both nurses and CHWs being strong and mutually supportive. If either is weak, the whole collapses. This has been confirmed by my research. The CHWs in Brown's Farm and Masiphumelele have struggled to perform this 'bridging' function as their efforts were hindered by nurses who were threatened by people who they were expected to share their 'territories' with. Seeing some of their functions being undertaken by CHWs, they often expressed understandable discontentment and resentment and withheld their vitally needed support.

A Study by Mathews, van der Walt and Barron (1994) which evaluated a CHW project in Khayelitsha, found that every community member who was interviewed expressed positive feelings about the project and appreciation of the CHW's visit and the health education it involved. The health education did not always relate only to narrowly defined health issues, and community members appreciated discussing social and personal problems with the CHW as this provided relief from anxiety. For some community members, the CHW visit was convenient, as access to clinics was a problem for them.

Many people believe that the most important role of the CHW is that of a 'change-agent' - as the person through whom communities become involved in health, and thereby take control of their own health (Walt 1988). For example, Freire's (1972) ideas of empowering communities through an educational process had a powerful effect on many people working in rural development. This

concept of 'conscientisation', together with experiences in non-formal education and community development and the Chinese 'barefoot doctor' experience, have led some to argue that CHWs were much more than community-based health service deliverers. They were seen as agents of change; catalysts in a development process who were challenging the medical profession's monopoly interest in health care (Rifkin 1978).

However, in South Africa this has not necessarily been the case. According to a study conducted by Hammond and Buch (1984) in Gazankulu, it was found that CHWs largely have failed to reach their participatory objectives. They provide the following explanation for this: *"In a politically, economically and socially oppressive country...perhaps it is inevitable that most such workers will represent yet another strand in the extensive web of control that officials already have over poor villages".*

The question of professionalism within the discourse around CHWs is something which requires more debate and discussion. At present CHWs do not belong to any labour organisation, their qualification is not accredited, and they have no official place within the district health team. There are at present few opportunities for promotion and it is assumed that once a CHW, then always one. The only career opportunity which exists for CHWs at present, is to be promoted to a supervisory role as a project co-ordinator.

Vaughan (1980) considers the problems which may be associated with the 'professionalisation' of CHWs. He believes that this would lead to loosening of local community bonds and loyalties. Although it might enable closer relationships with nurses, it could result in losing the trust of the community. There are many lessons to be learnt from the experiences in Jamaica, where CHWs were incorporated into the public health system. CHWs were introduced in Jamaica to foster links between the health service and the community. They have, however, tended to become increasingly remote from the community and to regard themselves as being based in health centres. They have also mounted a campaign for recognition as nursing professionals (Cumper & Vaughan 1985). A similar process was evidenced in my study. When the CHWs began to be seen as useful by the nurses, they were given more and more responsibilities within the clinics. CHWs enjoyed this feeling of status and began to experience confusion over loyalties between the clinic and their project.

In Jamaica, seven years after the introduction of CHWs, it is clear that their range of functions has narrowed. The links with the health centres have grown stronger but the availability of the CHWs as a source of information, advice and help in the community has diminished. The relationship between the CHWs and the nurses also changed. Instead of going to the clinic periodically to perform certain duties, the CHWs began to regard the clinic as their locus of practice, as modifications had been made to many health centre buildings to accommodate them (Cumper & Vaughan 1985). In Masiphumelele the CHWs operate out of an office within the clinic and this move was seen to improve relations with the nurses. It will however, be important to curb their overinvolvement within the clinic, as they have already been seen to be used as additional nursing staff when the need arises.

The move seen in other developing countries to bring CHWs into the professional grades has major financial implications. CHWs were introduced partly as a cost effective way of increasing access to health services and providing essential services in under resourced communities. Changing their status to that of a professional within a clinic would probably not be in the best interests of the health service. According to Skeet (1994) it negates the unique and most effective characteristic of the CHW - that of being one of the people. With that very special quality gone, the CHW becomes just another worker in the health care system. This will necessarily result in a reappraisal of the need for this cadre of health worker.

The question of whether to professionalise CHWs requires careful consideration. As can be seen above, professionalisation results in distancing from the community and greater involvement within the clinic. This is contrary to the philosophy behind CHWs and the role for which they are trained. However, one can not overlook the vague position which CHWs assume in many countries which may motivate them towards professional status. Efforts should therefore be made to clarify the position and role of CHWs within the district health team, providing accreditation for their qualifications and reorientation of health professionals to their role and functions, without incorporating them into clinics. In this way one can provide meaning, a sense of identity and most importantly credibility within the existing understanding of a CHW, without impairing their effectiveness.

6.2 CHALLENGES FACING COMMUNITY NURSING

The nurses in this study perceive their work to be valuable and worthwhile, in spite of its demanding and stressful nature. This is what makes their work meaningful. The nurses' perceptions that their work is valuable also arises from their perceptions that they are making a difference in the lives of their patients, and that they are needed. In part, making a difference is related to seeing positive outcomes, which is an important factor in their sense of job satisfaction. These perceptions have important implications for the role of community nurses in a reformed health care system as well as for the quality of nursing work-life.

There has been considerable discussion in recent years about the changes facing community nursing (Reutter & Ford 1996). Within the discipline of public health there has been a shift toward a socio- environmental view of health and a focus on health promotion principles and concepts rather than on curative care alone (Pederson, O'Neill & Rootman 1994). Increasingly, primary health care principles are seen as the foundation for public health nursing and have been reflected in altered conceptualisations of public health nursing roles (Chalmers & Kristjanson 1989). In many countries these changing views of community nursing practice are being played out in a context of health care restructuring and health care reform (Reutter & Ford 1996). While the literature advocates a more extensive scope of community nursing practice, the researcher has found a paucity of research that explores community nursing from the perspective of the 'grass roots' practitioner.

Since the first group of registered nurses was trained in clinical health assessment, treatment and care in 1982, South Africa has come a long way. Not only has the government policy declared nurses to be the 'backbone of the health care system in South Africa', but there has also been a major shift in health care focus from predominantly hospital-based services to the focus being placed on primary level care. The changes have made health care more accessible to the community. Primary level services were declared free for mothers and children under six in April 1995 and for all citizens in April 1996. However, according to the Child Health Unit, UCT (1999), in their impact assessment of the free health care policy, this approach has increased the case load that nurses have to handle at clinics without the health budget increasing to make provision for the increased patient load. The attitudes of nurses interviewed during this assessment indicate their feelings that the free health care policy has aggravated a number of existing problems within the health care services. These included poor working conditions, low pay, shortage of medicines, overcrowding, and poor staff morale. There was also a general

sentiment amongst the nurses that the implementation of such extensive changes should have been preceded by greater consultation and planning with health care personnel.

These changes have placed a tremendous burden on the clinic nurse. Nurses have been transferred to the clinics without the relevant training and education to deliver the services at clinic level. Human resource support was minimal. The so-called transformation and redistribution of resources consisted of offering voluntary severance packages to public servants. This resulted in a drain of expertise to the private sector and other countries. These posts were never filled, and while the staff establishment has decreased, patient numbers have risen considerably (Geyer 1999). This has led to the conditions under which community nurses work being demanding, complex and often contradictory. Community nurses, as compared with nurses based in a hospital setting, are accorded more autonomy and increased decision-making power. Yet many community nurses perceive their position, and also their functions in the clinics, to be characterised by ambiguity and confusion.

Most nurses in South Africa are still trained in tertiary hospitals, which does not prepare them adequately for work in the community setting. Hammond (1987) emphasises that to implement genuine primary level services requires nurses with specific knowledge and skills, and amiable attitudes to co-workers and community members. She believes that it is no longer acceptable simply to allocate a hospital trained nurse to an understaffed, ill-equipped rural clinic, to call her a 'PHC provider', and to assume that she will be offering comprehensive primary level services to the community. According to her: *"This is a classic example of primitive health care provision, not primary health care!"* In this study, the clinics were also found to be lacking in essential supplies and equipment. None of the clinics had a pharmacist and nurses were expected to perform this role, most with no prior training.

An example of the success of a training programme for registered community nurses can be found in Tintswalo Hospital in Mpumalanga. The emphasis in this course is on changing attitudes and recognising that many of the health problems experienced by South Africans have their roots in the complex social, economic and political environment in which people live. By understanding these root causes of ill health, primary health care nurses began to realise that to blame individuals for their ill health is to victimise them even further. Instead of scolding the mother who brings her malnourished child to the clinic, the primary health care nurses have

learnt to show respect and caring. They will, by their attitudes, increase the mother's ability to deal with her own difficult circumstances (Schneider, Malumane, Ngwenya & Blackett-Sliep 1989).

Another example of a community-oriented learning approach to undergraduate nursing education is the Bachelor of Nursing Degree offered by the University of Cape Town Department of Nursing. This programme was designed to anticipate the competing demands for radical change in both the health care system and the nursing education system (Kyriacos and Van Den Heever 1999). The curriculum of the undergraduate nursing degree embraces a health, whole person, and family focus. During their four years of study students are afforded many opportunities to engage with individuals and families. Long-term community placements enable them to learn a variety of interpersonal skills.

In my study it was clear that nurses in clinics are working under extremely stressful conditions. They are short-staffed, exhibit signs of burnout, and experience many limitations which impair their ability to provide high quality patient care. They describe feeling tired, irritable and despondent about their work. Benner and Wrubel (1989:372), believe that the separation of caregiving and caring leads to the modern epidemic of burnout, which is defined as the loss of human caring. They propose that: *"...when one is burnt out, things appear equally flat and meaningless. The world ceases to have meaningful distinctions. What once gave pleasure can feel like a demand."* This aptly describes the experiences of many nurses in this study who found themselves shouting at patients as the only way left to express the turmoil and struggles within themselves.

The nurses also experienced being undervalued and exploited by health care management. Many nurses in this study had frequently been moved without prior consultation and were often asked to fill posts for which they were neither trained nor experienced. This constant moving of staff hampers the formation of teamwork within clinics as nurses become despondent about the changes, and this leads to them being detached from their working environment. The sense of being 'unheard' and unsupported by management as a nurse is a frequent complaint. In a study by Walker (1995), interviews with nurses in Soweto revealed that they often have to contend with a hostile work environment which at times tends to lack support, definition and clarity, and therefore serves to heighten their feelings of isolation.

The frequent changes in staff impacts on the ability of nurses to work as a team, as they work in a climate of uncertainty. As described above, nurses are often moved to other clinics without their consultation or consent. Sadly, they have come to see this process as part of nursing. The resulting uncertainty within clinics diminishes nurses' sense of commitment to invest in new challenges. Such uncertainty can lead to a decreased sense of manageability and/or meaningfulness of work. Reutter and Ford (1996) argue that a sense of manageability is contingent on comprehensibility - being able to make sense of what is occurring, largely because information is consistent, structured and clear. This study suggests that uncertainty, when combined with decreased resources, appears to detract from a commitment to engage in creative endeavours.

In this study nurses reported that the high numbers of patients and problem of staff shortages leaves them being unable to provide the quality of care that they would like. The nurses in this study acknowledged the need to listen to patients, yet they felt that they did not have the time for this because of the long queue of people waiting for them. This confirms the findings of Walker (1995) in a study which investigated the practice of community nurses in Soweto. She showed that while the nurses dealt effectively with presenting clinical problems, they rarely entered into discussion about the possible social origins of the problems. This practice, where the emphasis is limited to the physical care of the patient, runs contrary to the philosophy of the PHC approach. Although real solutions to many of these problems are not easily found, Walker noticed that very little effort was put into addressing underlying problems or referring patients to appropriate social agencies.

The impact of staff shortages on nurses' ability to provide quality patient care was illustrated in a study by Dick and Pekeur (1995) which investigated the workload and work patterns of nurses at a local authority clinic in Cape Town. In this study it was found that only 52% of the clinic nurses' time was spent on direct patient care. This was due to both administrative pressures and a shortage of staff.

Many of the nurses in my study spoke about feeling powerless in the face of the desperate social conditions confronting their patients. In suggesting that clinic nurses should be 'socially competent', it is important to recognise that the socio-economic conditions in which their patients live are beyond the control and solution of the nurses. Primary level health services and nurses in particular cannot be expected to deliver what the economy of the country has failed to

bring about. While nurses can only be effective to the extent that socio-economic circumstances allow, such constraints should not detract from an effective and empathic primary level service. Walker (1995) believes that nurses' relatively powerless position within the health professions as a whole may also lead them to think that they are not in a position to take any sort of positive action for their patients.

A study by Reutter and Ford (1996) which investigated the perceptions of public health nursing by Canadian nurses, found that the most demanding aspect of the nurses work was dealing with socially disadvantaged families. Several nurses in their study remarked on the challenges presented by socially disadvantaged families. The nurses felt powerless to bring about changes that could benefit their clients because they did not have the skills or resources to address the underlying social problems faced by these families. The nurses also doubted that they were 'making a difference' and began to question how much energy to invest working with these families. In South Africa, where levels of poverty and 'social disadvantage' are higher, the job of the nurse becomes even more demanding.

While the emphasis of primary nurse practitioner training is understandably on developing clinical competence, working within the PHC approach requires that nurses also need to be 'socially competent'. At present only a small percentage of their training focuses on social concerns, yet primary nurse practitioners are being called on to confront the results and implications of social problems on a daily basis.

In the community setting the role of the nurse is to work in partnership with the community in all aspects of planning and evaluating health care services. The goals of nursing intervention are not to cure but rather to help individuals to take greater control of their own health and to bring health messages across which will assist in this process. The following nurse who works for an NGO which runs a CHW project, explains the deficiencies in nursing education in South Africa:

> "In South Africa, in order for us to come close to people on the ground, we should embark on training the nurses in primary health care and community health, you know how to deal with people on the ground. You are looking at where people are able to discuss what they want. Where people are able to tell you the kind of things that they want". *(RN3)*

A study by Matthews, van der Walt and Barron (1994) which evaluated a CHW project in Khayelitsha, found that community members who were interviewed experienced a great difference between CHWs and nurses with regard to the quality of the relationships. CHWs were seen to respond to people with an attitude of respect, while nurses' attitudes were perceived as lacking in respect and condescending, which in turn limited utilisation of services. This corresponds to the findings of my study which showed that a common emotion expressed by community members towards nurses was one of fear. This is a daunting reality to acknowledge and accept as it has serious implications for utilisation of health services and ultimately the health status of communities. We can have the most well-staffed, adequately-resourced health centres but they will be useless if people are too afraid to visit them. These findings need to be taken back to the nurses in a sensitive supportive manner in order for them to understand how their attitudes and behaviours are perceived by the people for whom they are meant to be caring.

If this is the situation for clinic nurses, how can we expect them to welcome CHWs whose mobilisation and awareness-raising in communities serves to bring the clinic 'more work'? It is under these circumstances that CHWs are pulled away from the community-based work for which they were trained, and get absorbed into routine clinic work, functioning as nurse aides in order to provide relief to the burnt-out nurses and fearful patients. Therefore, in order to achieve a mutually satisfying relationship between CHWs and nurses, greater attention should be paid to strengthening health centres through the provision and retention of permanent, suitable trained and supported nursing staff.

6.3 THE CLINIC AS AN ORGANISATION AND SOCIAL SYSTEM

Zwart (1972) suggests that a clinic may be studied or better understood as an organisation. A model, developed by the Netherlands Pedagogic Institute to assist managers identify problems in their organisations, has been applied by Dick and Pekeur (1995) to study the management of a clinic. This conceptual scheme describes an organisation as a complex system consisting of four essential components:

- *Resources* - equipment, manpower and buildings.
- *Procedures* - work processes and structure.
- *Relations* - co-operation, and the way people work together.
- *Mission* - politics, values, and the fundamental purposes of the organisation.

This conceptual framework exists in an external environment which affects it in many ways. The legal, cultural and socio-economic milieu impacts on how the organisation functions. Zwart (1972) postulates that in any organisation problems may occur at all levels. In practice they tend to cluster around one or two levels within an individual organisation; for instance management problems may result from lack of resources and ill-planned work processes.

Reina and Reina (1999:136) describe the importance of trust within organisations and the resulting effects when this is destroyed: *"Organisations depend on relationships to get most work done and to co-ordinate the efforts of their workforces. Relationships depend on trust to succeed. When leaders lose sight of this and orchestrate change without sensitivity and awareness towards the people affected by the change, they betray both themselves and the people."*

The issue of trust between nurses and CHWs in this study had a profound impact on the dynamics of their relationship. There was clear evidence of mistrust on both sides. The nurses in this study often felt unsupported and unheard by their management and this frequently led to a negative environment within the clinic. The mistrust between the nurses and CHWs had an obvious effect on their ability to establish a relationship.

A clinic can also be seen as a social system embedded in a medical culture and responsive to an encompassing regional social structure. Nichter (1986) argues that the ideology of PHC needs to be considered from the vantage point of health centre staff and in relation to issues involving professional status and personal motivation. He believes that the major problems present in health centres reflect inherent conflicts over knowledge, status and power associated with the process of professionalisation. In this study much of the conflict present between nurses and CHWs was related to power struggles and status. CHWs felt inferior to nurses because they are not professionals, and the nurses saw CHWs as a threat to their status and power. These conflicts led to role strain as CHWs became more involved in the clinic in order to feel more like professionals. The nurses encouraged the CHWs to work more in the clinic as it was a way for them to have control and therefore feel less threatened.

With reference to role strain within PHC teams, Nichter (1986) identifies that health centre staff are keenly aware of each other's status, which is in part determined by salary, specialized knowledge and access to sources of power and symbols of authority. He stresses that a delicate balance of power and status exists between cadres of health staff. Given this context, strains on

inter-staff teamwork may be expected when new cadres are introduced, the scope of duties of a cadre is broadened or merged with another group of workers, or when lay persons confuse the differences between cadres. In addition to status conflicts, this creates what Nichter (1986) has referred to as 'zones of ambiguity' - areas of overlap in role performance between professionals with different training and orientation.

The findings of this study confirm these processes. When a CHW project is established in a community there is role ambiguity as nurses are faced with a new cadre of health worker with no knowledge of their role or functions. This in turn causes strain on the relationship as nurses regard CHWs as a threat and attempt to counteract this by undermining them. As Nichter (1986) has shown, it is hardly surprising that nurses feel threatened and wish to control CHWs. For nurses, issues of status and future pay scale rationalisation depend on such control.

A further impediment to the development of cohesive relations between nurses and CHWs is what Drower (1988) describes as *"the chain of professionalism"* which binds nurses. She argues that professionalism leads to an elitist position which is upheld by many nurses, and which fosters divisiveness between nurses and clients, and between colleagues. She stresses that this runs in contradiction to the philosophy of PHC which places an emphasis on a multi-disciplinary team approach to service within a framework of democracy and equality. She proposes that the PHC approach has no place for *"health workers preoccupied with maintaining and guarding status positions"*.

A recent threat to the development of trust and teamwork within clinics is the move towards integration of curative and preventive services in order to overcome the fragmentation inherent in primary level services. At present, mainly curative services are provided in community health centres which are managed by the provincial administration, and predominantly preventive and promotive services are provided at clinics which are managed by the local authority. The Health Department plan is to place all primary level services within a defined geographical area under the control of a single authority.

This is proving to be an arduous task as the salary structures, working conditions and employment contracts differ dramatically between these two authorities. Provincial authority nurses' salaries range from 55% to 86% of mean local authority nurses' salaries. A report by Bachmann and Makan (1997) found that raising all salaries to the weighted average salary of local authority nurses would cost an extra R1.16 billion per year. This was about 10% of the entire

public sector health budget, or 21% of current salary expenditure. The hypothetical option of equalising salaries down to the level of the lowest earners would save R155 million, or 3% of current salary costs. The nurses in my study mentioned their fears and apprehensions about this process and there was an obvious awareness of the implications of these changes.

These discrepancies in salaries pose significant problems to the planned integration of these two groups of employees within one clinic. Bachmann and Makan (1997) believe that refusal of the National Department of Health to confront these issues could have severe consequences. Provincial administration nurses working alongside local authority nurses are likely to continue to feel aggrieved and demotivated if the salary differences are not addressed, and may refuse to co-operate with reforms. This will impair the proposed development of district health systems, which require preventive and curative services to be integrated, and nurses to work closely together.

The pattern of non-consultation seen in this study, not only between initiators of CHW projects and nurses, but particularly between clinic managers and their nurses, does not bode well for the impending integration of services. It is vital to consult with, and include, nurses in this process which will ultimately impact on their practice and working conditions. Failure to do so will impact on the ability of nurses to work as a team, and could result in a divisive, demoralising and disruptive environment. This will in turn affect relations between nurses and CHWs. Under these circumstances, CHWs may be seen as a further burden and threat to the already fragile and insecure state of nurses.

6.4 INFORMAL SETTLEMENTS AND THE CONCEPT OF COMMUNITY

CHW initiatives in South Africa have almost always been established in peri-urban informal settlements or isolated rural areas. These settings are poorly resourced and therefore CHW projects are an attempt to provide basic health services, to encourage utilisation of existing services, and to encourage preventive health practices. Perhaps the greatest value of the CHW concept is that the worker, by definition, comes from the community he/she is chosen to represent, and presumably stays in close contact with those people. Therefore CHWs are able to overcome barriers of language and culture which often confront a more highly trained medical professional who comes into the community from the outside. This social distance constitutes yet another 'gap' for the under-served rural or informal settlement population. As a member of the

community, however, the CHW is easily able to establish the much-needed bond of trust that facilitates the communication of health information between provider and patient.

The informal settlements or 'squatter camps' situated on the outskirts of most cities around South Africa emerged largely as a result of the combination of rapid urbanisation and the policies of the apartheid government. These policies restricted people of similar race to clearly defined geographical areas. Most blacks in urban areas were forced to live in areas characterised by low-cost housing (townships) or shanty homes (informal settlements). Both townships and informal settlements are almost exclusively residential areas, with industrial areas located adjacent to most of them (Yach 1988).

According to Yach (1988): *"Squatting should be seen as the first stage in the necessary process of urbanisation, and the squatter's shack as an initial form of housing needing upgrading - not demolition"*. In South Africa few resources were allocated to these areas and this has resulted in urbanisation having a profoundly negative influence on the health of communities living in informal housing (van Rensburg 1994).

The growth of these informal settlements around Cape Town has been particularly apparent over the past ten to fifteen years as there has been a progressive influx of people from the former 'homeland' areas. A move to the city holds the promise of a job, and opportunities for rapid improvement in a person's social, economic and health status. People feel that cities are able to offer employment, and provide educational and health facilities.

Nurses and CHWs in this study had different experiences of informal settlements. For the CHWs it is their home, and for the nurses it is the setting for their place of work. Nurses often found the environment of extreme poverty which characterises informal settlements, to be depressing. They felt powerless in the face of overwhelming socio-economic problems yet, acknowledged the need of patients to be listened to. The large patient numbers and staff shortages prevented them from being able to listen, and this exacerbated feelings of helplessness.

For the CHWs the informal settlement is their home and the patients are their neighbours and friends. This immediately alters their understanding of the challenges present within this setting. They are agents of change and are eager to improve the standard of health in the community as this will ultimately impact on them as residents there. CHWs are also part of the culture of their community and understand the influence of this on health-seeking behaviour. They are conscious

that people need to consult with family before making contact with formal health professionals, CHWs or traditional healers. Thus CHWs do not force themselves on community members but rather they respect that there is a certain process to be followed.

Within the discourse of CHWs, and the context in which they work, namely informal settlements, it is necessary to clarify what is meant by 'community'. The word community is a misleading term. It suggests an isolated group of people, living in a place with demarcated boundaries, of which membership is exclusive. Boonzaier and Sharp (1988:38) questioned the very existence of 'communities', but concluded that they do exist because people believe in them, desire them, and act as if they do exist as clearly bounded, homogenous social units. Thornton and Ramphele (1987) suggest that 'community' can be best understood as *"an image of coherence, a cultural notion which people use in order to give a reality and form to their social actions and thoughts."* And in a sociological context, Boonzaier and Sharp (1988:38) believe that: *"The existence of communities is founded on more or less intense social interaction among their members, which inevitably produces social boundaries defining them and giving them identity".*

A community is not a closed group; it is dynamic and is always in a constant state of flux. People come and go, and many belong to more than one community simultaneously. People can have multiple identities. In this study, many residents of Brown's Farm and Masiphumelele were found to have come from the former homeland areas of the Transkei and Ciskei. They came to Cape Town in search of employment, and many return to their original homes and families each year. Many people still have homes in rural areas which they maintain despite not living there. This is an indication that they have not ceased to be members of their original communities. Similarly, a man might fulfill different roles in the two communities. He might be a father and a husband in the Transkei, and in Masiphumelele a worker who sends money home to his family. He has different identities.

The term 'community', particularly within the South Africa context, also has political connotations. According to Thornton and Ramhele (1987): *"Communities are both the 'targets' for development, and their hoped-for result".* They indicate that the term has often been used by South African governments as a euphemism for 'race', a term which is at least as ill-defined as community. It has also been used to designate the targets, or victims, of government-planned 'community development' programmes which Thornton and Ramphele (1987) believe are *"at best often ill-conceived (though sometimes well intentioned), and at worst vicious and destructive."* 'Communities'

may also be the objects of legislation which determines access to resources such as housing, wealth, jobs, education and perhaps even a sense of identity.

In all these cases, the usage of the term does not guarantee that a 'community' actually exists. There may in fact be no willingness to co-operate, no coherent social organisation, no sense of belonging. Nevertheless, we often assume that the 'community' exists and that it will agree, cohere, follow or listen. Thornton and Ramphele (1987) question why politicians and scholars more frequently ask what is wrong with 'the community' than what is wrong with their assumptions. Communities do exist, but they cannot be assumed. Claiming them in order to legitimate a political programme or to support a plan of action does not create them.

In this study, despite the diversity of home origins of the residents of Brown's Farm and Masiphumelele, a strong sense of cohesion and social support was evident. One could conclude that this is on the basis of race, with both being almost exclusively black settlements. However, black nurses who work in these areas are considered outsiders, suggesting that the ties are related to geographic rather than racial closeness. With the profound changes that are taking place in health care and health care delivery systems, it is time for nurses to critically examine their beliefs and values surrounding the concept of community and community nursing practice. As discussed previously, it is apparent that communities form, but no-one really knows how. It is vital for all community nurses to acknowledge the complex social and political process which may have led to the establishment of a community, and to work with that. The clinic is not a separate entity within a community; it should be seen as part of the social network, functioning in collaboration with other resources, with joint planning and problem solving.

6.5 HEALTH SEEKING BEHAVIOUR AND THE CONCEPT OF *UBUNTU*

In the descriptions of CHWs' interaction with clients, there is often mention of neighbours being the contact people who call the CHWs. When making decisions regarding health care, it is part of black culture to consult with family first before approaching a CHW or formal health service (Pillay 1996). This is evidence of the importance of family and social networks.

The notion of 'family' within black cultures does not constitute a finite, autonomous unit. Studies in South Africa have shown that the notion of black families incorporates a vast range of family types and kinship structures (Ross 1995:4). It is apparent from the literature that a range of social sources inform peoples' notions of family, kinship and descent, and that these notions can be manipulated in such a way as to verify belonging and ensure assistance. Social bonds that use (imaginary) blood ties as a basis, and the moral obligation that are construed in these bonds, are frequently activated, particularly in times of need. Bonds may be defined on the basis of distant kinship or clanship, and indeed need not necessarily all be kin-based.

The search for healing and health in impoverished communities is one for which support networks are frequently activated (Ross 1995:17). This is especially noted in peri-urban areas where there is an attempt to retain ties with people originating from the same rural area. This support network, a response specific to blacks in South African, is also known as *amakhaya.* Ramphele (1993) comments on the reasons for this network: *"In a situation of scarce resources, appeal to all possible sources of support is crucial to survival. Constituting oneself as a neighbourhood-based organisation which entails moral obligations and rights, enables one to utilise a wide range of other people as a kind of support net. It also allows for the maintenance of links with areas of origin".* Wide ranging literature documenting the existence and activities of 'home person' groups (*amakhaya*) bears testimony to this fact (Mayer 1961).

Another aspect which seems to enhance social networks among black families is the notion of domestic fluidity. Ross (1995:31), arguing that *"the extended family and close neighbourhood relations can be a powerful coping device in the urban environment"*, points out that the stability of a set of social relationships along which goods and services can flow is an important component in the survival of a community. She also points out that there appears to be a tendency for kinship/descent structures to be of greater importance in rural areas, while neighbourhood and friendship ties take a degree of precedence in urban areas. She illustrates this further by commenting that on a

day-to-day basis among black residents in Grahamstown *"neighbours are probably the most significant internal economic resource...reciprocity and sharing is the basic principle underlying neighbourhood relationships...creating a therapeutically supportive environment"*. The following CHW describes how they rely on neighbours to assist them with home care or physically getting patients to the clinic:

> "Sometimes we feel we can help...we try to call the neighbours. And then we carry them to take them to the clinic". *(CHW4)*

The CHWs in this study live and work in communities where the majority of residents have relocated from the former homelands of the Transkei and Ciskei. Many families who once lived in the same village are now neighbours again within the context of a peri-urban informal settlement. With reference to the above discourse on kinship networks, CHWs see their 'patients' as neighbours and relate to them as such. This is perhaps the most striking difference between how nurses and CHWs interact with their patients.

The desire observed in CHWs to help their community characterises the African ethos which is based on collectivism, which has the '*ubuntu*' concept as its foundation (Goduka 1996). *Ubuntu* is a concept which is socially constructed and culturally located. Its meanings are created and contested, both by its practitioners and by social researchers trying to comprehend the ways in which it is used. *Ubuntu*, as the way in which humanity is manifested, is the socially constructed manner of relating to others and reflexively constituting oneself as belonging in society, and thence being recognised as a member of such. Thus, 'a person is a person by means of other people' (*umntu ngumntu ngabanye abantu)* (Ross 1995:41).

CHWs embody this concept through their practice. They believe that people cannot survive alone, and therefore utilise social networks to ensure that community members are supported. The process of consulting family and then CHWs before formal health services, also signifies the importance of neighbourhood and friendship ties. For CHWs, if the people in their community are healthy, then they will be healthy.

People's health beliefs strongly influence their health and illness behaviour. Such beliefs influence whether people treat themselves or consult family, friends or medical services. It is well known that cultural determinants play an important part in maintaining a sense of good health. Cultural values, norms and expectations influence and shape beliefs, lifestyles, family interactions, roles

and social organisation (Gochman 1988). Cultural influences affect not only perspectives on health, illness and disease, but also a variety of health related behaviours, such as beliefs that underlie the utilisation of services and seeking of medical care (Pillay 1996).

For blacks in South Africa, a traditional system of healing and health care exists alongside the Western medical system. Their cultural and social beliefs have been shown to contribute to the way they conceptualise illness and disease and use health care facilities. Traditionally they view illness in terms of natural, moral and magical aetiologies (Ngubane 1977).
Over the past four decades several theoretical models have been proposed in an attempt to explain or account for health behaviours. These include: the Health Belief Model (HBM) (Hochbaum 1958; Rosenstock 1974); model of illness and sick-role behaviour (Kasl & Cobb 1966); help-seeking model (Mechanic 1978); and a social learning model (Wallston & Wallston 1984).

According to Schlebusch and Ruggieri (1996), health behaviour research is in its infancy in Africa. Particularly in South Africa, where there is a growing incidence of diseases requiring high technology medical intervention (e.g. cancer and heart disease) within a large underprivileged population. There is a need to gain more cross-cultural health behaviour knowledge that would permit the formulation of health care education programmes specifically designed for local needs. In this process, exploring the health beliefs that motivate patients towards active or passive health-seeking behaviour is necessary to integrate individual health-care consumers' responsibility for their own health within existing primary level services.

A study by Pillay (1996) conducted in Kwazulu-Natal, South Africa, investigated the help-seeking behaviour of urban black people and proposed a model of help-seeking behaviour for this particular group. With regard to illness disclosure and the practice of consulting neighbours and family members, 86% of patients in this study talked about their illness and concerns to others prior to attending the hospital, while only 13.2% did not. Only 2.5% had spoken to a doctor as their initial contact person. This highlights the importance of family and neighbourhood ties in providing support and direction.

The model proposed in Pillay's (1996) study describes the process involved when urban black people seek help for illness. He suggests that urban blacks have a specific personal conception of illness, health and disease that influences their manner of help seeking. A graphical representation of this model is presented below:

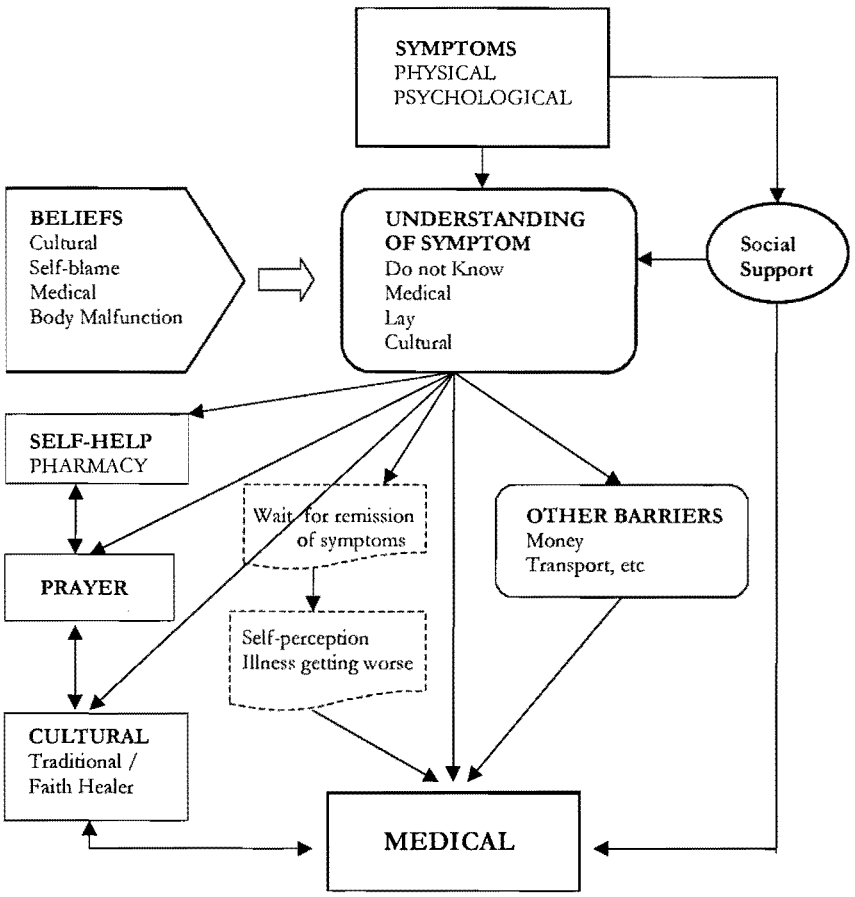


Illustration 15: **Model of help-seeking behaviour for urban blacks (Pillay 1996)**

According to Pillay (1996), the experience of symptoms alerts the individual to changes taking place in health status and commences the process of help-seeking. The symptoms experienced by the patient are both physical and psychological. The symptoms that are experienced are evaluated in the context of the individual's personal conception of health and illness. The study which led to this model has uncovered further evidence to support the view that the urban black person's conception of health and illness is holistic. Health is viewed as feeling good, well, comfortable, free in body and mind and includes the feeling of contentment with life. This can also been seen in the philosophy and practice of CHWs. They consider health to be broader than physical needs and spend much time in skills development and facilitating learning. For example, they assist people to grow vegetables and teach them about correct storage of food and aspects of hygiene.

A change in any of the above aspects of health, constitutes illness. This leads the person to seek an understanding of their symptoms. This is referred to as the stage of alertness. The individual will disclose this experience or feeling to others. The purpose of illness disclosure is to help the individual make sense of his or her symptoms. The support and disclosure is most often to the mother, other family or friends.

During the stage of alertness the individual tries to understand or attach meaning to the symptoms. In addition, the views of others (to whom the individual has exposed his illness), and the individual's beliefs and past experiences will also play a crucial role in establishing meaning for the symptoms. Pillay (1996) suggests that beliefs may be categorised into four main areas: cultural, self blame, medical or body malfunction. On the basis of the meaning or understanding of these symptoms active help-seeking begins.

Help-seeking behaviours will vary. Help seeking may be separated into four broad areas, namely self-help, prayer, cultural and medical. Only about 20% of people in Pillay's study visited a doctor immediately. About 40% monitored their symptoms and at the point at which they thought that it was serious enough only then would they visit a doctor. In some instances the delay in visiting a doctor was due to other barriers such as financial constraints, lack of transport, availability of appointments and sick leave.

According to Pillay (1996), medical help-seeking is probably the result of learned behaviour, sanctioned socially accepted behaviour, and the result of Western influences on the understanding of illness and health. The proposal that medical help seeking is a learned response, is based on several observations of ways in which the behaviour could have been reinforced. These days, more and more black babies are being born in hospital and not, as in the past, at home by midwives. As a result, the individual is exposed from birth to hospitals, doctors and clinics. Even pregnancy, a normal developmental process, is medicalised because of the development of specialised obstetric care and the fact that a pregnancy is treated as a 'disease' where the mother is required to attend antenatal clinics. The follow up care at clinics after birth to monitor birth weight and the immunisation of children further reinforces this view. Visits to the doctor and the interaction with the doctor leads to a learned response by the individual. These learned responses could conflict with the urgent call for people to take 'responsibility for their own health'.

Other factors that influence the choice and selection of medical services are the location and perceived quality of the service provided. The people in my study were influenced in their help-seeking behavior because of fear related to how they are treated at the clinic. It seemed that along with 'consulting' CHWs as neighbours, many people chose to consult them because they needed support in their encounters at the clinic.

In South Africa, nurses are often confronted with situations in which patients' requests, understanding of problems and solutions are derived from beliefs and world views markedly different to their own. According to Chipfakacha (1994), the first contact between a black African patient and health care services usually takes place in the traditional healing system. Therefore health workers should realise that an understanding of the traditional system is important if the PHC approach is to succeed. A health care system is a cultural system just as like language or religion.

Chapter 7
IMPLICATIONS AND CONCLUSION

7.1 IMPLICATIONS OF THIS RESEARCH

7.1.1 Implications for nurses working in informal settlements

It is clear from this study that community nurses are working under extremely stressful and demanding conditions. The working environment in these clinics is characterised by short staffing, high patient numbers, nurses being moved to other clinics without being consulted, nurses feeling unsupported by management, and symptoms of burnout. If this is the first point of contact of patients with the health system then we need to be asking some serious questions about the current quality of care in these settings.

The setting of an informal settlement provides further challenges to the nurse due to the context of extreme poverty and few resources. The nurses in this study found this environment to be sometimes depressing and hopeless. They spoke of feeling powerless in the face of such overwhelming socio-economic problems, and this led them to question the value of their interventions.

The nurses were aware of their patients' needs for a listening ear, yet the high numbers of patients and shortage of staff prevented them from spending enough time with individuals to allow for sharing of deeper issues. This was frustrating to nurses who felt that they were not able to develop trusting relationships with their patients.

It is also important to note that the nurses measured their efficacy by concrete measurements such as the number of patients they had 'cured' or the disease statistics of the area, rather than by less measurable means such as caring or whether they have spent time with clients. This indicates the task-oriented practice into which nurses have been socialised. They are expected by their managers to account for their work in terms of concrete measurable means. This places them in a double bind as they have to process scores of patients through a system, yet this system is so impersonal that it turns patients into numbers. There is no time available for meaningful communication, which would allow patients and nurses to get to know each other's concerns. The nurse feels like a failure when a patient is not 'cured' and cannot receive reward from other interventions such as helping a patient to understand the disease process or to cope better with it.

This has serious implications for the quality of care which patients at the primary level receive. Considering that a large proportion of visits to the clinic or health centre may be due to social hardships such as domestic problems, problems associated with unemployment, addictions, rape or child abuse, these issues cannot be fully assessed within a five minute pressured consultation. Therefore issues of staffing need urgent attention in order to provide the comprehensive service which the primary health care approach advocates.

Another aspect of the present primary level service which does need to be addressed is the support provided to nurses. The general feeling amongst nurses in this study is that they do not receive adequate support from their management. It is clear that nurses are moved between facilities without their agreement, and that they are frequently placed in positions for which they are neither trained nor sufficiently experienced. This has serious implications for both team building within clinics and staff morale. If nurses feel undervalued their work becomes meaningless and unfulfilling, which in turn impacts on the quality of the service which they are capable of providing.

According to Bachmann and Makan (1997) the failure of the Department of Health to address the crisis within clinics is related to the perception that nurses have few alternative employment opportunities, and are thus unlikely to leave the public service despite unsatisfactory working conditions. Such abuse of power towards the largest cadre of health workers in the country is clearly not going to improve the current crisis in health care. How can we expect nurses to carry the burden of implementing primary level services in an effective manner when support from the highest level is severely lacking?

While greater support and acknowledgement of nurses is important, attention should also be focussed on the training requirements of nurses for work in the community setting. Many of the nurses in this study had been trained in tertiary centres with minimal attention to primary level care. The course which is most often undertaken by nurses working in clinics is geared toward the development of clinical skills in diagnosis and treatment in order for nurses to become clinical practitioners, but tends to leave them lacking in the social and interpersonal requirements of primary level work.

Thus nurses enter the clinics with little knowledge of mechanisms through which they can involve community stakeholders such as health committees or residents' committees. In order for there to be a shift in the approach of nurses towards patients and other health workers such as CHWs, there needs to be a change in the training of nurses to prepare them more adequately for the unique needs of the community setting. A rather disturbing yet common finding in this study was how patients experienced clinic nurses - the overwhelming reaction was one of fear. In their encounters with people in the community, CHWs inform people about the clinics, and encourage them to use these health facilities. They are faced with great reluctance and frequently have to act as mediators, as many people will not enter the clinic without the support of a CHW. This forces us to ask serious questions about the true acceptability of the services on offer.

In this study some of these fears related to language problems, especially in Masiphumelele, a Xhosa speaking community, where the first Xhosa speaking sister was only appointed during the period of this study. Patients experienced frustration at not being understood and therefore not receiving the care which they expected. These encounters also led to nurses taking out their own frustrations on the patients in a negative manner. Therefore it is clearly necessary to consider language when planning the allocation of nursing staff. A clinic in a Xhosa speaking area with no Xhosa speaking sisters is certainly not going to be able to meet the needs of the community, and is thus not an acceptable service.

The addition of a new cadre of health worker requires a change in the traditional role of nurses. This requires regular discussion, and changes in the continuing education of nurses. Nursing staff also need orientation and training to learn how to deal with consultative processes.

7.1.2 Implications for CHW projects

The emphasis on community-oriented delivery of care places great importance on the CHW as the individual who serves as the 'interface' between the formal health care system and the community.

As indicated in this research, one of the main obstacles to the full realisation of the CHW role is the lack of clarity on their role and functions. CHWs are expected to 'slot in' where no gap has been opened for them. They face a constant struggle for recognition within a health system which ignores both their presence and the vital role which they fulfill. The findings of this research suggest that there is an initial stage of deep hurt on the part of CHWs when a new

project is first initiated. They have just returned from training and are eager to begin work, only to be confronted with mistrust and scepticism. As described in the results, the CHWs face their referrals being ignored, their decisions questioned, and their role undermined. This is a painful and unnecessary process, and could be avoided if nurses were involved in the planning and implementation of these projects from the start.

Where this involvement has not occurred, as in the experience of this research, the only way for the nurses to feel comfortable and to have control over the threat they are facing, is to exploit it. Thus CHWs become an extra pair of hands in the clinic. Within the an environment of being exploited by nurses it is very easy for CHWs to disregard their role as a bridge between the community and the health service, and to assume greater responsibilities within the clinic where they feel that they have a purpose and are acknowledged. This is a disastrous situation which leads to further power struggles and exploitation, as well as the complete loss of the real function of the CHW. In order for CHWs to find meaning and fulfillment within their work there needs to be clarity on their role and place within the new district health system. Without this they are forced to seek meaning within another role, that of an auxiliary nurse, and the unique position of the CHW working in the community is lost.

An important finding which has implications for the role of nurses within their relationship with CHWs, relates to the expectation of CHWs that nurses should be their mentors and facilitate their 'professional growth'. Nurses are placed on a pedestal by CHWs because they have the credibility of being professionals. The CHWs often spoke about how disappointed they were in the nurses' behaviour which they expected to be more mature, based on their own perceptions of professionalism.

It is important to be aware of the results which indicated that many CHWs dream of becoming nurses. They struggle with the lack of professional identity in the CHW role and many have chosen it as a stepping stone to becoming nurses. It is within the acknowledgement of this finding that one can understand the ease with which CHWs are drawn into clinic work and lose sight of the essence of their role. This reinforces the importance of providing accreditation and credibility within the CHW role.

The nature of health-seeking behaviour, as it emerged in this study, has implications for the role of CHWs and nurses within the district health system. It seems that black people undergo a complex process of decisions making when faced with changes in their health status. Findings from this study and others (Schlebusch & Ruggieri 1996; Pillay 1996) suggest that family and friends are the first point of contact, and it is within this group that an initial decision is made. Being members of the community where they work, CHWs are frequently the friends or neighbours who are called upon during this stage. With their training and knowledge of both traditional needs and Western medical practices, they are able to combine these approaches in the guidance that they offer.

CHWs are, therefore, uniquely situated to provide a link between their community and the formal health services. Within the paradigm of a rapidly changing health service this link is vital to prevent alienation of communities from a service which is increasing in its technology and 'medicalisation' of health care.

Conflict of interests, conflict of power, and lack of understanding are just some of the obstacles to partnership between nurses and CHWs. Yet without this co-operation, it will be impossible to link health actions with broader community goals.

7.1.3 Implications for the District Health System

Changing a health system from one pattern to another is always difficult, but trying to change the shape of a health system that is already in a state of turmoil into a new model is proving to be even more challenging. For the past five years, health managers have been trying to create a district health system where the current provincial and local authority clinics are integrated into a single system. The idea is that this will create a more rational structure, avoiding duplication of services, and in the end will be more responsive to the needs of the community.

Of primary importance to the successful implementation of the district health system is a national commitment to this strategy, as well as the dedication of the necessary resources to achieve such a goal. At present each province has the autonomy to manage this process in its own way. In the Western Cape forums facilitated by the Initiative for Sub-District Support have been held to bring all stakeholders together. Planning has focused around service provision, with a new core package of primary level services being designed, as well as methods to make services more

accessible to people. The CHW and community rehabilitation worker have been highlighted by various regional task teams as mechanisms through which this goal can be achieved.

The vision is for a qualitative change in health care, which will mean emphasising the PHC approach and seeing health in its intersectoral context. It is vital, however, to recognise that change is a difficult process which requires nurturing. It involves moving away from what people know, to something new and threatening. If both nurses and CHWs are not involved in this process at a broader level, and collaborative processes are not facilitated, then one cannot expect them to be able to work together at the local level in the clinic. It is imperative to acknowledge that the district health service is delivered predominantly by nurses and CHWs. Based on this acknowledgement and the results of this study, it is evident that without a more cohesive relationship between these two groups we cannot realistically expect the district health system to function.

If the aim is truly to integrate services it is imperative that formal guidelines be established concerning the role of the CHW, as the findings of this research suggest that much confusion exists around this role. Without this clarity services at the district level will continue to be fragmented, with mistrust and suspicion prevailing between health workers. It is also important for there to be good communication and referral channels between NGO health projects and the formal health services. Formal structures and regular meetings are essential to iron out uncertainty and to build a good team.

The link between local government and health districts is a logical one given the need for local accountability, the importance of community participation, and the need to meet local health needs. However, the reorganisation of health services as mandated by the constitution and the policies of the Department of Health continues to pose challenges to all health workers, whether they are managers or front line service providers. It remains important to focus on the vision whilst attending to the details of implementation. Keeping the lines of communication open and involving all stakeholders in the process will enable us to move toward our goals with more certainty and purpose.

7.2 LIMITATIONS AND RECOMMENDATIONS

7.2.1 Limitations of the Study

The qualitative research described in this thesis provides an in-depth analysis of the nature of the relationship between a small sample of nurses and CHWs who work in two particular communities. It aims to enrich understanding and yield new insights. The situational, in-depth nature of qualitative research precludes duplication and generalisation of results to other contexts. However, the two areas chosen for this study are fairly representative of the dynamics involved in community clinics throughout South Africa and the findings hold lessons for health provision in this context.

The language differences between myself and most of the research participants was to some extent a limitation in this study, although on reflection I still feel that it was right not to have involved a translator. Although all of the participants were required to speak English as a requirement for their job, some nurses and CHWs were unable to express themselves as fully in English as they could have in their home language. During the analysis of interview transcripts I frequently had to consult Xhosa-speaking colleagues in order to understand concepts and practices which are unique to the Xhosa tradition.

As described in the findings, nurses are working in an environment of extreme stress and pressure, characterised by shortages of staff and high patient numbers. This made it extremely difficult for me as a researcher to request some of this limited time. There were many occasions when I had made appointments to interview nurses but on the day a crisis had occurred and they could not spare the time to be interviewed. The interviews were also limited in time as the nurses were unable to leave their particular tasks for more than half an hour. This meant that the nurse was often not relaxed or focussed during the interview, being preoccupied with returning to her task. The difficulty which I experienced in accessing nurses has major implications for health researchers, as the practice of nursing is a paradigm which requires much inquiry in order to monitor the current changes in the health system.

A further aspect of this study which had both advantages and limitations, was my role as co-ordinator of the CHW project in Masiphumelele. This was a limitation in the sense that the CHWs often saw research activities as being directly related to the project and their work. Despite my explanations of the difference between my two roles, they saw the interviews and focus groups as work requirements rather than as participation in a study. This meant that they

were eager to assist but frequently did not expand on descriptions because they presumed that I already understood the context. I constantly had to remind them to pretend that I knew nothing about the project, but this was not always easy for participants.

7.2.2 Recommendations for Further Study

Further inquiry is needed into the most appropriate role for the CHW within the new district health system. Focus should be on determining the present needs of informal settlement communities and the most appropriate way in which these can be met by CHWs.

An investigation of the relationship between community nurses and their managers is also important during this stage of integration of services. It is also necessary to determine the support needs of community nurses and the ways in which these can best be met by managers.

The training needs of nurses working in the community setting also requires further investigation in order to explore different options and modes of learning, such as problem-based learning, or experiential learning. These methods would enable the development of reflective practice, and the interpersonal and facilitation skills which are vital for community nursing. There is a need to embark on a different approach to conducting research, namely the route of participatory action research in the evaluation of the current move towards integration of services. This is based on the assumption that if nurses were involved as co-researchers in a process of discovery, they would be able to study their own practice, and be better able to detect shortcomings and to plan and implement a different approach. As indicated by this study, nurses, like most people, tend to resist change, unless the managers making such changes are informed by an understanding of the underlying anxiety and defences which influence nursing practice.

7.3 CONCLUSION

Although the South African government has endorsed the primary health care approach as the best means by which to improve our nation's health, it cannot be said that these endorsements have been followed by national policy decisions or by fundamental reorientation of resources, both of which are vital if the concept is to be translated into reality.

This study has highlighted the demanding, complex and contradictory conditions under which community nurses have to work. In so doing it has raised a number of questions pertaining to relationships of power and authority which exist in the clinics. Understanding and exploring the relationships between nurses and CHWs working in a primary level setting and within the PHC approach has raised some important and complex questions. It is not enough simply to say that these relationships need to change in order to create a less conflictual working environment. Rather, the fears and concerns of both groups need to be acknowledged and a process to facilitate an understanding of each other's roles and functions should be put into place in order for relationships to be developed.

The need to confront these issues is becoming more pressing as the demand for more primary level services increases, while the corresponding supply of resources and manpower does not. Furthermore, these issues should be examined within the context of the health services as a whole, particularly as nurses are being trained in institutions in which the PHC approach is not always central to their teaching. The current transitionary period in South Africa provides a necessary and important opportunity in which these issues can be confronted and changed.

Being the largest group of health professionals employed by the clinics, the high level of stress and dissatisfaction amongst nurses is cause for serious concern. If community nurses are to provide the best possible health care to the community, they need to be supported and their feelings acknowledged. This is vital if the philosophy of the primary health care approach is to be realised in practice. If clinic nurses felt more supported by their management, it would enable them to have more confidence as a group and they would be more prepared to work with CHWs. The reality, however, is that they report feeling burnt out, are short-staffed and feel unheard by their management. This is a completely unsuitable environment for CHWs to enter as co-workers, making the process of establishing this relationship much more complex.

These findings can be used to provide support for nurses during this time of uncertainty and to design strategies that will ensure their optimal contribution to enhancing community health. With the impending integration of services, and the changes which this will bring, there is a need to ensure that the work of community nurses is manageable and meaningful.

Rowe's (1980) definition of crisis epitomises the present state of primary level services in South Africa: *"One world has died; another is powerless to be born...The experience of it is the experience of crisis or dilemma, or being condemned to the anxious space between the no longer and the not yet"* (cited by Benner & Wrubel 1989: 369)

The 'no longer' applies to a fragmented health care service with centralised authority and poor support for nurses, and the 'not yet' is the planned integration of services and the creation of the district health system. We are presently suspended in the chasm between these two situations. Uncertainty characterises the environment in most health centres, as the unknowns of future salary structures, place of work, functions and expectations hang in the air while politicians and managers deliberate.

For the CHW there is also uncertainty as to whether they will have a role in the district system. Will they be considered part of the health team, or will they remain 'illegitimate' and have to face yet another struggle for recognition within a changed clinic structure?

These are questions which remain unanswered, yet have a direct impact on the relationship between CHWs and nurses. At a time where uncertainty characterises the working environment of both groups, and efforts are spent in protecting each identity, any form of cohesion or partnership remains a dream.

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CHW7 Working as a CHW for 1 year Male	We are the people who are encouraging progress around this community. I mean community progress. To work hand in hand together with people of the community.	Health broader than physical encompasses general upliftment in living conditions. Working together - participation	Health as a broad concept	Caring for the whole	**The experience of working in an informal settlement**
CHW8 Working for 1 year Female	They are not scared to go from house to house. There are people in their homes who are sick, who didn't have a chance to go to hospital or who hadn't got the know - ledge of hospitals or nurses. And some are scared.	People still need home visits as there is a significant knowledge gap around health care. Fear is an important emotion and barrier to seeking health care.	Home visits still vital due to lack of knowledge about health services and fear.	Health within the context of a home	**Belonging to the community**
RN1 3 years in Nomzamo clinic	Very stressful, and I think they made us very despondent. Because we are working like a team... and then one of the sisters had to be moved to Hout Bay and it made us upset because we've been working so well as a team.	Management does not take into consideration team building- they just move people when they want to. Destroy any attempts to work together. ? that's why team work is so hard for them.	Management destroys team spirit	Being moved	**Experiences of clini nurses**
RN5 Working in BF for 3 years	In fact they should be helping us- telling the people about us. Because they know the people, they are staying with them in the community. So if you work hand in hand with them, it's very easy for you to penetrate the community. Making it easy for you to get somewhere.	CHWs inform people about the clinic and are a bridge between the people and the services. Helping the nurses to gain access.	CHWs as a link between the people and the services	CHWs as bridges between the clinic and the community	**"CHWs are there when we are not"**

APPENDIX B

CONSENT TO PARTICIPATION IN RESEARCH

COMMUNITY HEALTH WORKERS AND PROFESSIONAL NURSES:
A DESCRIPTIVE STUDY OF THEIR RELATIONSHIP IN TWO WESTERN CAPE COMMUNITIES

I _____ (print name) hereby certify that I understand the purpose of this research and consent to participate in this study.

I understand that I will remain anonymous and that I have the right to withdraw from this study at anytime if I choose to do so.

The Undersigned (participant)_____

Date _____

As Witnessed by 1: (researcher)_____

Date _____

As Witnessed by 2: (translator)_____

Date _____

APPENDIX C

AUDIT TRAIL

The purpose of this audit trail is to clarify my thought processes and feelings in sorting and categorising data, and to conceptualise patterns that emerged during analysis. This enables the reader to identify how the research process resulted in the findings presented.

Period	Research Activity	Research Outcome	Key Challenges
Jan to April 1999	• Developing research question • Initial visits to potential sites • Writing research proposal	• Submission of research proposal • Informing nurses and CHWs in both areas of the study	Identification of the research question
April to July 1999	• Site visits and 'immersion' in the field • Participant observation • Recording of field notes	• Developing a relationship with nurses and CHWs • Gaining an under - standing of processes and organisational structures within the projects and services	Gaining access
July to December 1999	• Developing skills in interviewing and focus group facilitation • Conducting individual interviews • Interview transcription	• Gaining skills in free attitude interviewing • Becoming more accepted and welcomed by the participants	Successful interviewing techniques
Jan to March 2000	• Analysis of individual interviews • Identifying descriptive categories • Checking findings with co-analyst • Constructing questions for focus group validation	• Emergence of concepts and early categories • Identifying concepts which required further exploration and understanding	Rigorous analysis procedure
April to May 2000	• Conducting focus groups • Re-look at the literature • Thesis writing	• Emergence of new and validation of existing categories • Data saturation • Emergence of final descriptive categories	Construction of questions for focus group validation
May to August 2000	• Thesis writing	• Integration of literature and findings • Thesis production	Producing a coherent thesis

(Adapted from Britton 1999)

EXPANDED AUDIT TRAIL

Initial site visits

From the time that I began my involvement with establishing the CHW project in Masiphumelele I was intrigued by the relationship between the CHWs and the nurses. It was fraught with difficulties from the start and I really needed to understand this better as it was a fundamental impediment to the full realisation of the CHWs' role within this community.

I chose Brown's Farm as the other site as I had worked with the CHWs there as a student, so I knew the environment and had a link with that community. My initial visits to the clinics were difficult as I encountered much scepticism.

After my first site visits I left all three clinics feeling completely disheartened and my initial preconceived ideas about clinic nurses being unwelcoming and uncaring were confirmed. It took a few days for me to gather the courage to try again. After reflection and speaking with other researchers, I decided that perhaps wearing my uniform would facilitate access to this group, as they might be able to identify with me and not see me so much as an outsider. I had chosen not to wear it before because I was worried that they might see me as someone in a management position, and I feared that they might then give me what they perceived to be the 'right answers' instead of portraying the situation as it is.

On my next visits I wore my uniform and also took eats for the staff. As I suspected they did not remember who I was, and I had to give my initial explanations again. The greeting was, however, remarkably different. I was immediately shown to the head sister who gave me her undivided attention and agreed to discuss participation in the study with the other staff members. The following visits were all much easier as I had been identified as 'one of them' and was greeted and able to engage in conversation easily with people who remembered why I was there. I'm sure the tea and cake also played a part!. No doubt about it, one of the maddening though constructive truths of becoming a qualitative researcher is that one must learn by doing.

Unfortunately, even the uniform and food did not make the process of accessing willing participants an easy task. The nurses seemed very reluctant to be interviewed and I was aware of their suspicions. I would phone and make appointments with staff and then arrive to find that they had either gone to a meeting or claimed to be unaware of the appointment and were too busy to talk to me.

I remember one occasion particularly as I felt especially hurt and betrayed. I had made an appointment to interview two sisters, making the arrangement through the clinic manager as that was the channel through which I was instructed to work. When I arrived I discovered that none of the staff had been told about my visit and I went from room to room seeing if anyone was available. What hurt the most was that the nurse I had previously interviewed pretended not to know me and chose to ignore me.

The head sister had gone to a meeting and had left no message in the communication book, so that staff were not prepared to help me. I approached the sister who was second in charge and explained my predicament to her. She was not interested and told me to wait in the waiting room. I sat for half an hour feeling more and more despondent when eventually a sister approached me and said, "Come, I'll talk to you otherwise you'll be here all day". She said it in such a way that I felt like a real nuisance to her. I really did not want to conduct an interview with someone who felt obliged to help me or who felt pity for me. It was a terrible interview. She was looking at her watch constantly and kept asking, "Is there anything else," and I felt completely disheartened and angry.

I don't feel as if I ever really reached a point in any of the three clinics where I was truly welcomed or where they were interested in my study. This was difficult for me and so I in turn never really enjoyed or was able to relax during my visits there. I realise that the situation in many clinics is such that time is of the essence and sisters are burnt out and stressed, but there seemed to be something more than that. I got the impression that change is something which is feared, and perhaps I was eliciting ideas around change or pushing them to think differently about their practice which may have been challenging or even threatening.

Data Collection

Once I had spent sufficient time observing in each setting I set about asking the nurses and CHWs if they would be willing to be interviewed. The CHWs were extremely accommodating and set aside a venue for me to use. Unfortunately, a quiet place in an informal settlement is not easy to find. In Masiphumelele there is the continuous sound of music in the streets and even inside the clinic one can still hear it. In Brown's Farm there was a church situated next to the one clinic so one heard singing all day. The general business of the clinic also prevented total quiet but I soon got used to this and just put up with poor quality recordings of interviews.

The irony in the difference of approaches towards me between the nurses and CHWs really struck me the day I arrived in Brown's Farm for the focus group with the nurses. I went to set up the venue and found one of the CHWs mopping the floor and arranging the chairs for me. She asked: "Will there be more than twenty nurses?" I had spent the past week confirming this focus group and every time I phoned I was given another reason why more of the nurses couldn't attend. On the day I was hoping that four would arrive. This CHW believed so strongly in the importance of my research and in the hope that their relationship with the nurses would be changed through it, that she went to all the effort of preparing the venue herself. I was completely overwhelmed and realised the graveness of the situation which the CHWs wanted so desperately to change.

Situations such as the one described above also led me to feel that I should be facilitating change and collaborative processes during this research. I constantly had to resist the pressure to develop interventions to improve the relationship between the nurses and CHWs. This pressure was largely due to my own anxiety of being a member of the health team and wanting to 'fix' the problems before they are completely understood.

Analysis

During the analysis process many themes emerged which needed further exploration and understanding in the focus groups. Some of these themes were, however, related to aspects of race, and I was unsure how to ask about them in a sensitive manner. I was aware of the delicate position in which I would be placing myself, and the risks involved. I brought these concerns to a mentor discussion group and it was felt that it was imperative to gain clarity on these issues, despite the risk of giving offence.

The main understanding which I needed to capture was around the feeling of black nurses that they belonged in a particular community even though they did not live there. I spent some time constructing an appropriate question which hopefully would facilitate a discussion around this concept. In the focus group two of the four nurses engaged this question and gave fairly similar responses. It was interesting to note that the nurse who works for the NGO felt much more comfortable discussing this than the other nurses. This was perhaps an indication of the differences in structure and hierarchy between these two organisations, with relative freedom of expression and ideas within NGOs.

Concluding Reflections

The process of conducting this research was challenging for me, both as a nurse and as a researcher. I encountered situations which left me feeling embarrassed and ashamed to be part of the nursing profession. I had to resist the urge to be critical of the nurses who seemed at times blatantly negligent and disrespectful towards patients.

I was very pleased with the decision to conduct interviews prior to the focus groups as this enabled me to develop relationships with some nurses and to begin to understand the underlying anxiety and defences which influence their nursing practice. Throughout this process my skills as a researcher were moulded and honed. I began as an inexperienced researcher who was frightened by the thought of having to conduct a focus group, and was somewhat overwhelmed by the richness of the data that I collected. I end this process as a researcher who has taken risks, opened myself up to be vulnerable, faced rejection and learnt the meaning of perseverance.

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Data Collection

Once I had spent sufficient time observing in each setting I set about asking the nurses and CHWs if they would be willing to be interviewed. The CHWs were extremely accommodating and set aside a venue for me to use. Unfortunately, a quiet place in an informal settlement is not easy to find. In Masiphumelele there is the continuous sound of music in the streets and even inside the clinic one can still hear it. In Brown's Farm there was a church situated next to the one clinic so one heard singing all day. The general business of the clinic also prevented total quiet but I soon got used to this and just put up with poor quality recordings of interviews.

The irony in the difference of approaches towards me between the nurses and CHWs really struck me the day I arrived in Brown's Farm for the focus group with the nurses. I went to set up the venue and found one of the CHWs mopping the floor and arranging the chairs for me. She asked: "Will there be more than twenty nurses?" I had spent the past week confirming this focus group and every time I phoned I was given another reason why more of the nurses couldn't attend. On the day I was hoping that four would arrive. This CHW believed so strongly in the importance of my research and in the hope that their relationship with the nurses would be changed through it, that she went to all the effort of preparing the venue herself. I was completely overwhelmed and realised the graveness of the situation which the CHWs wanted so desperately to change.

Situations such as the one described above also led me to feel that I should be facilitating change and collaborative processes during this research. I constantly had to resist the pressure to develop interventions to improve the relationship between the nurses and CHWs. This pressure was largely due to my own anxiety of being a member of the health team and wanting to 'fix' the problems before they are completely understood.

Analysis

During the analysis process many themes emerged which needed further exploration and understanding in the focus groups. Some of these themes were, however, related to aspects of race, and I was unsure how to ask about them in a sensitive manner. I was aware of the delicate position in which I would be placing myself, and the risks involved. I brought these concerns to a mentor discussion group and it was felt that it was imperative to gain clarity on these issues, despite the risk of giving offence.

The main understanding which I needed to capture was around the feeling of black nurses that they belonged in a particular community even though they did not live there. I spent some time constructing an appropriate question which hopefully would facilitate a discussion around this concept. In the focus group two of the four nurses engaged this question and gave fairly similar responses. It was interesting to note that the nurse who works for the NGO felt much more comfortable discussing this than the other nurses. This was perhaps an indication of the differences in structure and hierarchy between these two organisations, with relative freedom of expression and ideas within NGOs.

Concluding Reflections

The process of conducting this research was challenging for me, both as a nurse and as a researcher. I encountered situations which left me feeling embarrassed and ashamed to be part of the nursing profession. I had to resist the urge to be critical of the nurses who seemed at times blatantly negligent and disrespectful towards patients.

I was very pleased with the decision to conduct interviews prior to the focus groups as this enabled me to develop relationships with some nurses and to begin to understand the underlying anxiety and defences which influence their nursing practice. Throughout this process my skills as a researcher were moulded and honed. I began as an inexperienced researcher who was frightened by the thought of having to conduct a focus group, and was somewhat overwhelmed by the richness of the data that I collected. I end this process as a researcher who has taken risks, opened myself up to be vulnerable, faced rejection and learnt the meaning of perseverance.